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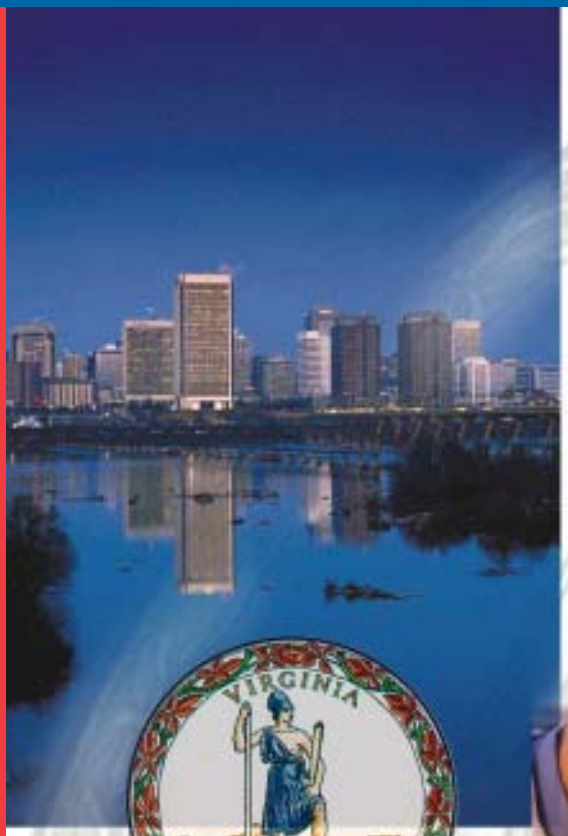

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Virginia Premier Health Plan

CY 2005

We don't provide healthcare... we make it better.

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Virginia Premier Health Plan – Operational Systems Review

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This annual report will include the overall results of the Operational Systems Review as well as the findings related to quality, access and timeliness of care.

The Operational Systems Review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva evaluated the following systems:

- Enrollee Rights and Protections (ER) —Subpart C Regulation
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems (GS)—Subpart F Regulation

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva conducted a comprehensive review of Virginia Premier Health Plan (VPHP) to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services using the results of the Operations Systems Review.

The results of the OSR are contained in this report and are first analyzed by standard (Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance Systems). After this analysis, performance on these standards are assessed relative to quality access and timeliness of services provided to the MCO's members. Strengths and opportunities for improvement are also identified for use in further quality improvement efforts. It is expected that each MCO will utilize the review findings and recommendations found in this report to implement operational systems improvement to become fully compliant with all standards and requirements.

Background on Plan

VPHP provides managed care services to Medallion II enrollees in various localities throughout the state of Virginia. Enrollment in December 2005 for VPHP was 102,035 members. Localities covered by VA Premier are Tidewater, Central Virginia, Charlottesville, Roanoke, and Winchester regions. VPHP began providing services to Medallion II enrollees in January 1996 and is a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited health plan.

Data Sources

Delmarva used many data sources to assess compliance with the operational systems standards. Information was requested from the MCO and reviewed by Delmarva prior to the on-site review. At the time of the on-site review additional data were collected through staff interviews and review of additional documents and systems. Data sources include, but are not limited to:

- Policies and Procedures
- Interviews with MCO staff
- Credentialing Files
- Complaint, Grievance and Appeals Files
- Committee Meeting Minutes (Quality, Credentialing, and Utilization Management)
- Member Materials
- Provider Manuals and Materials
- Internal MCO Staff Training Information
- Quality Improvement Projects
- Focused Studies
- Annual Quality and Utilization Management Program Evaluations

Methodology

The VPHP Operational Systems Review assessed activities performed by the MCO during the time frame of January 1, 2005 through December 31, 2005 (CY 2005). The purpose was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The review incorporated regulations set

forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq*. In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights (ER) and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation
- Grievance Systems (GS)—Subpart F Regulation

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

The operational systems standards used in the calendar year (CY) 2005 review were the same as those used in the 2004 review period (January 1, 2004-December 31, 2004) and in the 2003 review period (June- December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "unmet." Each element that was not fully met in the 2003 review was assessed as part of the calendar year (CY) 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or unmet in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO' had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified. The CY 2005 review included a review of all operational systems standards as in prior reviews and was conducted on-site at the MCO as in the 2003 review.

Consistent with all prior reviews, Delmarva staff completed the review using all information provided by the MCO which included, but is not limited to policies, procedures, interviews, review of complaint, grievance appeals, and credentialing files. Each element within a standard was rated as "met," "partially met," or "unmet". Elements were then rolled up to create a determination of "met", "partially met", or "unmet" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Unmet	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. In CY 2005, all standards were reviewed as in the 2003 review. This provides the DMAS with a current evaluation of the processes that have been developed, implemented, and/or remain in place since the 2003 evaluation.

The results of the OSR are then applied to the categories of quality, access, and timeliness of services for a final analysis.

Results by System

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2005 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Partially Met
Subpart D- Quality Assessment and Performance Improvement	Partially Met
Subpart F- Grievance Systems	Partially Met

A total of 47 standards are evaluated as part of the Operational Systems Review. Five (5) of the seven (7) Enrollee Rights standards were met, and two (2) were partially met. Of the 29 Quality Assessment and Performance Improvement standards, 27 were met and only two (2) standards were partially met. Of the 11 Grievance Systems standards, nine (9) were met and two (2) were partially met. Although one *element* received a determination of unmet, none of the *standards* received a review determination of unmet.

Results for each of the 47 Operational Systems Review elements contained within each of the three standards are presented in Table 3.

Table3. 2005 Operational Systems Review Results for VPHP.

Standard Number	Standard Description	Element Ratings Met/Partially Met/Unmet	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	11/0/0	Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	13/1/0	Partially Met
ER 3	Information and language requirements	7/1/0	Partially Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	5/0/0	Met
ER 6	Advanced directives	5/0/0	Met
ER 7	Rehabilitation Act, ADA	3/0/0	Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met
QA 5	Cultural considerations	1/0/0	Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met
QA 8	Direct access to specialists	3/0/0	Met
QA 9	Referrals and treatment plans	0/1/0	Partially Met
QA 10	Primary care and coordination program	2/1/0	Partially Met
QA 11	Coverage and authorization of services: processing of requests	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	2/0/0	Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	1/0/0	Met
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Unmet	Standard Rating
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	1/0/0	Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	3/0/0	Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	8/0/0	Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	1/0/0	Met
GS 4	Content of notice action	5/0/1	Partially Met
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	4/2/0	Partially Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met
GS 9	Resolution and notification	3/0/0	Met
GS 10	Requirements for state fair hearings	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 standards, by element are found in Appendix I-A2.

Results by Outcome

Quality, Access and Timeliness

This portion of the annual report provides an evaluation by Delmarva, as the EQRO to assess the progress that Medallion II managed care plans have made in fulfilling the goals of DMAS related to quality, timeliness, and access. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

Although Delmarva's task is to assess how well VPHP performs in the areas of quality, access, and timeliness from the operational systems review perspective, it is important to note the interdependence of quality, access, and timeliness. Therefore, a measure or attribute identified in one of the categories of quality, access, or timeliness also may be noted under either of the two other areas.

Quality, access, and timeliness of care are expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report. An analysis by quality, access, and timeliness follows.

Quality

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population.

VPHP performed well in the areas of enrollee rights and protections- staff/provider, availability of services, cultural considerations, provider selection, quality assessment and performance improvement program, basic elements of QAPI program, and filing requirements for notices of action.

VPHP has policies and procedures to provide for a second opinion from a qualified health care professional within the network or to obtain one outside the network, at no cost to the enrollee. Female enrollees have direct access to a women's health specialist within the VPHP network for routine and preventive services. There are provisions to allow enrollees to receive services outside of the VPHP network when not available in the MCO's network. Enrollees with special health care needs are also able to have a specialist as their PCP. In addition, VPHP's policies permit a 12-month unlimited referral to a specialist for those members who have chronic or recurring health care needs that are best service by specialists.

Although VPHP has appropriate policies and procedures in place to address enrollees with special health care needs, there is no mechanism to monitor the timeliness of the implementation of treatment plans. In order to receive a determination of met in future reviews, the MCO must implement procedures to assess and monitor timeliness of the development and implementation of treatment plans.

The Cultural Considerations policy outlines the procedures in place to promote the delivery of services in a culturally competent manner. VPHP has identified Spanish speaking members as more than 5% of its membership. In response, the MCO had made available the Member Handbook and other vital documents in Spanish. Interpreter and translation services are offered free-of-charge to enrollees and the Member Handbook informs enrollees of this benefit.

A comprehensive Credentialing Program Description is in place. The credentialing and recredentialing process does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment. There are also procedures in place to address monitoring of delegated activities.

VPHP has implemented various policies and procedures to ensure enrollee confidentiality and privacy. These policies and procedures address both the HIPAA and DMAS contractual requirements for confidentiality and privacy.

Authorization processes are in place. It is noted that the MCO does not require preauthorization for emergency care, family planning services, preventative services, and basic prenatal care. Inter-rater reliability procedures are in place to ensure consistent application of criteria used in making authorization decisions. Provider-enrollee communications are encouraged. The authorization policies also allow for staff to consult with the requesting providers when appropriate. Authorization decisions are made by appropriate health care professionals with the necessary clinical expertise in treating the enrollee's condition or disease. Time frames for authorizations and notification of denials meet contractual requirements. There are no incentives in place

for denying, limiting or discontinuing services for enrollees. In addition to standard authorizations, there are also procedures in place to provide expedited authorizations to meet the exigency of the situation. Time frame extensions, of up to 14 days, are also allowed when it is determined to be in the best interest of the enrollee.

The appropriate clinical practice guidelines are also in place. These include preventive and disease specific guidelines. These are distributed to providers and to members upon request. The process used to select and/or develop guidelines ensures they are based on reliable and valid clinical evidence or a consensus of health care professionals. All guidelines are reviewed at least every two years.

The MCO is required to have at least one quality improvement project in place. VPHP has developed and implemented a project entitled Quality Control in Asthma Management. Interventions were deemed to be appropriate and progress is monitored through the quality improvement channels.

The grievance and appeals system is in place and meets the majority of requirements. Time frames for resolution are consistent with requirements. The notices of action (NOAs) are written according to language and format requirements, including the action taken, reasons for the action, procedures to file an appeal, and the right to a State Fair Hearing. The NOAs do not include the circumstances under which the enrollee has the right to request that benefits continue during an appeal, information that the enrollee is able to provide additional information, and a description of the limited time available for expedited appeals.

Access

Access is an essential component of a quality-driven system of care, and historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access as evaluated through the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance Systems standards are described below.

As noted in the section on quality, VPHP enrollees have access to a second opinion from a qualified health care professional within or outside of the network at no cost to the enrollee. Female enrollees have direct access to a women's health specialist within the VPHP network for routine and preventive services. There are provisions to allow enrollees to receive services outside of the VPHP network when not available in the MCO's network. Enrollees with special health care needs are also able to have a specialist as their PCP. In addition, VPHP's policies permit a 12-month unlimited referral to a specialist for those members who have chronic or recurring health care needs that are best service by specialists.

VPHP has procedures in place to ensure enrollee access to emergency and post-stabilizations services, emergency transportation, and other medical transportation.

In regards to access and availability of services, VPHP has the appropriate standards in place that meet contractual requirements. The Oversight of Network Adequacy policy describes procedures used by the MCO to ensure that network providers are in compliance with these standards. The Network Development Committee oversees monthly monitoring as well as the corrective action plans that are implemented to address noted deficiencies.

The grievance and appeals policy outlines the procedures to ensure access to the grievance and appeals process including the right to request a State Fair Hearing. However, the policies and procedures do not require the NOAs to include the circumstances under which enrollees have the right to request that benefits continue pending an appeal resolution and the circumstances under which the enrollee may be required to pay the cost of services. In addition, not all of the NOAs reviewed included the right to submit additional information and none of them addressed the limited time frame available for filing an expedited appeal.

Over and underutilization of services is also assessed. In 2005, the specific areas addressed included mental health, inpatient care, and outpatient drug utilization patterns.

Members have access to free interpretation and translation services. At the time of the last review, it was noted that the Member Handbook stated these services were available, but did not note they were free-of-charge. This has not been addressed and remains partially met.

Timeliness

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. Delmarva assessed the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance System standards to evaluate VPHP's commitment to timeliness of services.

Although VPHP has appropriate policies and procedures in place to address enrollees with special health care needs, there is no mechanism in place to address the timeliness of the implementation of treatment plans. In order to receive a determination of met in future review, the MCO must implement plans to assess and monitor timeliness of the development and implementation of treatment plans.

VPHP is in compliance with the HIPAA confidentiality and privacy components. In addition, the MCO's policies ensure that VPHP will make an individual's personal health information (PHI) available to the

Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.

The authorization policies and procedures are in compliance with requirements in regards to time frames. Service authorizations are required to be completed within two (2) days of receipt of all necessary information. There is an expedited authorizations process which requires a notice as expeditiously as the enrollee's health condition requires and no later than three working days after the request. There are also provisions for time frame extensions if it can demonstrated that an extension is in the enrollee's best interest.

The time frames for resolution of grievances and appeals are consistent with DMAS and Federal requirements. However, the NOAs do not contain a description of the limited time available for expedited appeals. This must be addressed in order for VPHP to receive a determination of met for the next review.

Overall Strengths

Quality:

- Twenty even (27) of the 29 Quality Assessment and Performance Improvement standards were met.
- The credentialing policies and procedures are in place and functioning well based on a review of provider credentialing and recredentialing files.
- The MCO completed an analysis of issues related to cultural competency. VPHP identified that greater than 55 of their enrollees were Spanish speaking and now provides these enrollees with vital documents in Spanish.
- Procedures are in place to afford members the opportunity to have freedom of choice among network providers.
- Members can receive a second medical opinion at no cost to the enrollee.
- Members with special needs can request a specialist as their PCP.
- Female members have direct access to women's health specialists within the MCO network for routine and preventative care services, including obtaining obstetrical and gynecological services without a referral.
- VPHP has policies and procedures in place that address confidentiality and privacy of member information requirements as required by HIPAA and the DMAS contract.
- Qualified individuals are used to make utilization management decisions. VPHP prohibits individuals from being provided incentives for denying, limiting, and/or discontinuing medical services.
- Clinical practice guidelines including preventive and disease specific guidelines are in place, are developed using a sound process. These are updated at least every two years for distribution to providers and are available to members upon request.
- Inter-rater reliability procedures are in place to ensure the consistent application of utilization management criteria.

Access:

- The VPHP Member Handbook is comprehensive and provides members with a description of the MCO benefits and services.
- VPHP has documented the appropriate access standards which are assessed on at least an annual basis. Their findings are documented in a report with recommendations for improvements where deficiencies are identified.
- As noted in the Quality section, VPHP affords members the opportunity to have freedom of choice among network providers, receive a second medical opinion at no cost to the enrollee, and to request a specialist as their PCP.
- Female members have direct access to women's health specialists within the MCO network for routine and preventative care services, including directly obtaining obstetrical and gynecological services without a referral.
- Members have access to out-of-network services when VPHP is unable to provide needed services within its network.
- The pre-authorization procedures are in place with no incentives for staff to deny, reduce or limit services.

Timeliness:

- VPHP has pre-authorization procedures in place and functioning within their processes. The timeliness completion of pre-authorization activities is monitored through the appropriate channels.
- There are expedited authorization procedures in place to ensure that enrollees receive timely decisions in cases where extenuating circumstances exist.
- Turn-around timeframes for authorization of services are outlined in policies, are in accordance with contractual requirements, and allow extensions when requested by enrollees. Timeliness of these decisions is also monitored through the quality improvement channels.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for VPHP are as follows:

- Members have access to free interpretation and translation services. At the time of the last review, it was noted that the Member Handbook stated these services were available, but did not note they were free-of-charge. This has not been addressed and remains partially met.
- Although VPHP has appropriate policies and procedures in place to address enrollees with special health care needs, there is no mechanism in place to address the timeliness of the implementation of treatment

plans. In order to receive a determination of met in future review, the MCO must implement plans to assess and monitor timeliness of the development and implementation of treatment plans.

- The time frames for resolution of grievances and appeals are consistent with DMAS and Federal requirements. However, the NOAs do not a description of the limited time available for expedited appeals. This must be addressed to receive a determination of met for the next review.
- The grievance and appeals procedures outline the processes to ensure access to the grievance and appeals process including the right to request a State Fair Hearing. However, the policies and procedures do not require the NOAs to include the circumstances under which enrollees have the right to request that benefits continue pending an appeal resolution and the circumstances under which the enrollee may be required to pay the cost of services.
- Not all of the NOAs reviewed included the right to submit additional information. VPHP must ensure that this information is included in all NOAs to be compliant with the requirements.
- None of the NOAs in the appeals files reviewed addressed the limited time frame available for filing an expedited appeal. The NOAs must be revised to include this element to meet expectations

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Appendix IA1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.	X			
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.	X			
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.		X		To receive a determination of met in future reviews, VPHP must have procedures in place to provide information on physician incentive plan for those enrollees who request it.
2.13	Procedures to share information with enrollees that they are not liable for payment in the case of MCO insolvency.	X			
2.14	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10)					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.		X		In order to receive a met in future reviews, VPHP must modify the policy and the Member Handbook to reflect that translation services are provided to members free of charge.
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.	**X**			
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	**X**			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	**X**			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	**X**			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	**X**			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	X			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	X			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	X			
ER6. Advanced Directives					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	X			
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	X			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	X			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.	X			
ER7. Rehabilitation Act, ADA					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.	X			
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA1. 438.206 Availability of services (b)					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	X			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	X			
QA2. 438.206 Availability of services (b)(2)					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	X			
QA3. 438.206 Availability of services (b)(3)					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	X			
QA4. 438.206 Availability of services (b)(4)					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations.					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care.					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.		X		To receive a determination of met in future review, VPHP must revise its policies and procedures to include timeframes for completion of the treatment plans. The policies and procedures must include a mechanism to measure the timeliness of completion of treatment plans.
QA10. 438.208(e) Primary Care and Coordination Program					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.		X		To receive a determination of met in future reviews, VPHP must ensure that it can demonstrate through documentation that there is continuity and coordination between medical and behavioral health care for co-existing conditions.
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action.					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	X			
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination.					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation.					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines.					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals and	X			
d)	Are reviewed and updated periodically, as appropriate.	X			
QA24. 438.236 (c) Dissemination of Practice Guidelines					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems.					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. accepting and processing enrollment b. Reconciling reports of MCO enrollment/eligibility c. Accepting and Processing provider claims and encounter data d. Tracking provider network composition, access to services, grievances and appeals e. Performing QI activities	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data b. Screening the data for completeness, logic, and consistency c. Collecting the service information in standard formats for DMAS d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements	X			
GS4. 438.404 (b) Content of Notice Action Content of NOA explains all of the following:					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.			X	In order to receive a finding of met in future reviews, VPHP must include a statement, in the notice of action, that identified the members' right to request that benefits be continued while the appeal resolution was pending or that the member may be held liable for the cost of services if the appeal outcome is unfavorable.

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.		X		In order to receive a determination of met in future reviews, VPHP must ensure that the current version of the notice of action, which includes the right to submit additional information, must be used to be in compliance with this element.
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.		X		In order to receive a determination of met in future reviews, VPHP must ensure that the current version of the notice of action, which include the limited time available for cases of expedited resolution must be used to be in compliance with this element.

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	X			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	X			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	X			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	X			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals					
8.1	MCO has an expedited appeal process.	X			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	X			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Appendix IA2 - Detailed Findings

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.

Element 1.1 – Enrollee rights and responsibilities.
This element is met.

The Virginia Premier Health Plan (VPHP) Member Rights and Responsibilities Policy contains a detailed description of the member's rights and responsibilities. According to the policy, member rights and responsibilities are communicated upon enrollment through distribution of the VPHP Member Handbook. Member rights and responsibilities are also communicated through VPHP member newsletters.

Practitioners and providers receive a statement of the member's rights and responsibilities through the Provider Manual.

Element 1.2 – Out-of-area coverage
This element is met.

The Routine Care Out of Service Area or Out of Network Policy describes how VPHP members may obtain out-of-area services. The procedures are communicated to members in the Member Handbook.

Element 1.3 – Restrictions on enrollee's freedom of choice among network providers (431.51)
This element is met.

The Member Handbook states that members may choose their primary care providers (PCPs) from the VPHP Provider Directory. Members with disabilities and chronic illnesses may ask to have a specialist serve as PCP. Members who do not select a PCP are assigned one by the MCO. Members may change PCPs if they are not satisfied with the PCPs chosen by or assigned to them by calling VPHP's Member Services Department. VPHP's Changing Primary Care Physician Policy outlines the MCO's internal procedures for responding to members' requests to change PCPs.

Element 1.4 – Referrals to specialty care (422.113c)
This element is met.

VPHP requires members to be referred for specialty care by their PCPs. These referrals must be approved by the MCO's Medical Management Department. The In Plan Referral System Policy and the Out of Plan Referrals Policy describe the procedures employed by the MCO to review and approve requests for specialty care. The Member Handbook provides information to members on the process of referral to specialists.

Element 1.5 – Enrollee notification – termination/change in benefits, services or service delivery site.
This element is met.

The Information Distribution Policy states that members will be notified of coverage and benefit changes through mailings to their homes, the member newsletter, and revisions of the Member Handbook. The MCO provided an example of a mailing to members notifying them of changes in VPHP's dental coverage for children.

Element 1.6 – Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is met.

The Member Handbook states that VPHP's Member Services Department is available to members Monday through Friday from 8:00 a.m. to 5:00 p.m. and can be reached by local and toll-free telephone numbers. The department also has separate local and toll-free telephone numbers for hearing-impaired members and provides translation services for those who do not speak English. The Member Services Department may be contacted to answer questions about VPHP and its benefits, assist members in choosing or changing a PCP, and provide assistance in arranging transportation to appointments.

Element 1.7 – Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is met.

The Member Inquiries and Grievance Processes Policy and the Appeal Process for Clinical Issues Policy outline VPHP's procedures for resolving grievances and appeals. These procedures address the fair hearing processes for VPHP and the State of Virginia Department of Medical Assistance Services

(DMAS), which are communicated to members in the Member Handbook.

The Appeals Process for Clinical Issues Policy includes a provision that FAMIS members may file an appeal with Delmarva Foundation for Medical Care, Inc. (Delmarva), DMAS's external review organization, once they have exercised their appeal rights through VPHP. FAMIS members must submit their appeal through DMAS and not directly to Delmarva Foundation.

Element 1.8 – List of non-English languages spoken by which contracted provider.
This element is met.

The VPHP Provider Director includes the languages other than English spoken by providers, including those serving as PCPs, specialists, and practicing within medical groups, where applicable, in its listings. Members receive a copy of the directory upon enrollment.

Element 1.9 – Provider-enrollee communications
This element is met.

The Member Rights and Responsibilities Policy state that members have the right to ask questions of their doctors/PCPs. The policy also states that members have the right to have their doctors inform them of treatment choices regardless of cost or benefit coverage. Member rights and responsibilities are published in the Member Handbook and in member newsletters.

Element 1.10 – Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

The MCO Insolvency and/or Contract Termination Policy state that members will not be held liable for debts of VPHP in the event of insolvency. The policy further states that the MCO will notify members of MCO insolvency and/or contract termination thirty (30) days prior to notification to DMAS to avoid interruption of members' medical care.

Element 1.11 – Enrollment/ Disenrollment.
This element is met.

The Member Handbook describes VPHP's member enrollment and disenrollment procedures.

ER2. Upon enrollment and according to expected time frames, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures): Is there suppose to be a list added here?

Element 2.1 – Enrollee rights and responsibilities.
This element is met.

The VPHP Member Rights and Responsibilities Policy contains a detailed description of member rights and responsibilities. According to the policy, member rights and responsibilities are communicated upon enrollment through distribution of the VPHP Member Handbook. Member rights and responsibilities are also communicated through VPHP's member newsletters.

Element 2.2 – Enrollee identification cards – descriptions, how and when to use cards.
This element is met.

The Member Handbook states that every VPHP member is provided with an identification card upon enrollment. Members are directed to carry their ID cards at all times and to present them each time they receive medical services, and they are warned not to allow anyone else to use their cards. The ID card includes the member's name, identification (ID) number, the effective date with the MCO, PCP name and telephone number, the Member Services Department telephone numbers, and the VPHP Nurseline telephone number for medical assistance when his or her doctor's office is closed. Information regarding the appropriate use of ID cards was also provided to members in 2005 through the member newsletter.

Element 2.3 – All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is met.

The Member Handbook includes a section detailing covered services and limits placed on them, and explains how services may be obtained outside the VPHP system.

Element 2.4 – Procedures for obtaining out-of-area coverage.
This element is met.

The Routine Care Out of Service Area or Out of Network Policy describes how VPHP members may obtain out-of-area services. The procedures are communicated to members in the Member Handbook.

Element 2.5 – Procedures for restrictions on enrollee's freedom of choice among network providers
This element is met.

The Member Handbook states that members may choose their PCPs from the VPHP Provider Directory. Members with disabilities and chronic illnesses may ask to have a specialist serve as PCP.

Members who do not select a PCP are assigned one by the MCO. Members may change PCPs if they are not satisfied with the PCPs chosen by or assigned to them by calling VPHP's Member Services Department.

Element 2.6 – The MCO's policy on referrals for specialty care.
This element is met.

VPHP requires members to be referred for specialty care by their PCPs. These referrals must be approved by the MCO's Medical Management Department. The In Plan Referral System Policy and the Out of Plan Referrals Policy describe the procedures employed by the MCO to review and approve requests for specialty care. The Member Handbook provides information to members on the specialist referral process.

Element 2.7 – Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is met.

The Information Distribution Policy states that members will be notified of coverage and benefit changes through mailings to their homes, the member newsletter, and revisions of the Member Handbook. The MCO provided an example of a mailing to members notifying them of changes in VPHP's dental coverage for children. The Member Handbook includes language reflecting this policy.

Element 2.8 – Procedures on how to contact enrollee services and a description of the functions of enrollee services
This element is met.

The Member Handbook states that VPHP's Member Services Department is available to members Monday through Friday from 8:00 a.m. to 5:00 p.m. and can be reached by local and toll-free telephone numbers. The department also has separate local and toll-free telephone numbers for hearing-impaired members, and provides translation services for those who do not speak English. The Member Services Department may be contacted to answer questions about VPHP and its benefits, assist members in choosing or changing a PCP, and provide assistance in arranging transportation to appointments.

Element 2.9 – Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is met.

The Member Handbook includes a section detailing covered services and limits placed on them, and explains how services may be obtained outside the VPHP system.

The Member Inquiries and Grievance Processes Policy and the Appeal Process for Clinical Issues Policy outline VPHP's procedures for resolving grievances and appeals. These procedures address the fair hearing processes for VPHP and the State of Virginia Department of Medical Assistance Services (DMAS), which are communicated to members in the Member Handbook.

The Appeals Process for Clinical Issues Policy includes a provision that FAMIS members may file an appeal with Delmarva Foundation, Inc., DMAS's external review organization, once they have exercised their appeal rights through VPHP. FAMIS members must submit their appeal through DMAS and not directly to Delmarva.

Element 2.10 – Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is met.

The VPHP Provider Director includes the languages other than English spoken by providers including those serving as PCPs, specialists, and practicing within medical groups, where applicable, in its listings. Members receive a copy of the Provider Directory upon enrollment.

Element 2.11 – Procedures for provider-enrollee communications.
This element is met.

The Member Rights and Responsibilities Policy state that members have the right to ask questions of their doctors/PCPs. The policy also states that members have the right to have their doctors inform them of treatment choices regardless of cost or benefit coverage. Member's rights and responsibilities are published in the Member Handbook and in member newsletters.

Element 2.12 – Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is partially met.

The Member Handbook states that VPHP does not provide incentives to providers for denying, limiting, or discontinuing medical services. The Member Rights and Responsibilities statement, documented in the Member Rights Policy and the Member Handbook, indicates that members have the right to receive

information about VPHP, its services, and providers. However, the policy did not specifically address procedures for distributing information to members, on request, regarding any physician incentives used as part of provider's reimbursement.

To receive a determination of met in future reviews, VPHP must have procedures in place to provide information on physician incentive plan for those enrollees who request it.

Element 2.13 – Procedures to share information that enrollees are not liable for payment in case of MCO insolvency.
This element is met.

The MCO Insolvency and/or Contract Termination Policy state that members will not be held liable for debts of VPHP in the event of insolvency. The policy further states that the MCO will notify members of MCO insolvency and/or contract termination thirty (30) days prior to notification to DMAS to avoid interruption of members' medical care. Language reflecting this policy was found in the Member Handbook.

Element 2.14 – Process for enrollment and disenrollment from MCO.
This element is met.

The Member Handbook describes VPHP's member enrollment and disenrollment procedures.

ER3. Information and Language requirements (438.10).

Element 3.1 – MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) its particular service area.
This element is met.

The Cultural Considerations Policy states that VPHP will identify populations where English is not the primary language of the member. According to the policy, VPHP makes member materials available in languages other than English for populations that exceed 5% of the MCO's membership. At all other times, the MCO provides translation services to members to facilitate the exchange of information in their native tongue.

The MCO reported that Spanish-speaking members currently exceed 5% of VPHP's population. Consequently, the Member Handbook and other materials have been printed in Spanish.

Element 3.2 – Enrollee information is written in prose that is readable and easily understood.
This element is met.

The Flesch Readability Formula Testing Policy indicates that VPHP ensures member materials, such as the Member Handbook, are comprehensive yet written to comply with readability requirements. A review of the Member Handbook, Provider Directory, and sample member newsletters provided evidence that member materials are readable and easy to understand.

Element 3.3 – State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).
This element is met.

The Flesch Readability Formula Testing Policy states that member materials will be written to achieve a Flesch Readability Formula score of 40 or better (at or below a 12th grade educational level). The MCO uses the Flesch scoring tool within Microsoft Word to review its member materials and submits them to DMAS for final review and approval after the needed scoring requirements have been met.

Element 3.4 – Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents are "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program) [and] . . . notices advising LEP persons of the availability of free language assistance."
This element is met.

The Translation Services Policy states that the AT&T Language Line is used to translate and explain member materials to members in other languages, as needed. The Member Handbook informs members that VPHP has bilingual speakers onsite to assist them, in addition to the AT&T Language Line. Members who need translation services are directed to call the Member Services Department for assistance.

The MCO reported that Spanish-speaking members currently exceed 5% of VPHP's population. Consequently, the Member Handbook and other vital documents have been translated and printed in Spanish.

Element 3.5 – MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is met.

The Translation Services Policy describes VPHP's use of the Virginia Relay Center (VRC) to provide information to members in alternative formats. The Member Handbook provides a toll-free telephone number for members to contact VRC to receive oral translation of materials if they are visually impaired or have limited reading proficiency and TTY/TDD services if they are hearing impaired.

Element 3.6 – MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.
This element is partially met.

The Translation Services Policy states that the AT&T Language Line is used to translate and explain member materials to members in other languages, as needed. The Member Handbook informs members that VPHP has bilingual Member Service representatives onsite to assist them, in addition to the availability of the AT&T Language Line. Members who need translation services are directed to call the Member Services Department for assistance. Although the policy and handbook information does not specifically state that translation services are free of charge, VPHP's Director, Quality/Credentialing stated that the MCO is not allowed to bill members for these services.

To receive a determination of met in future reviews, VPHP must modify the policy and the handbook to reflect that translation services are provided to members free of charge.

Element 3.7 – MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.
This element is met.

The Translation Services Policy states that the AT&T Language Line is used to translate and explain member materials to members in other languages, as needed. The Member Handbook informs members that VPHP has bilingual speakers onsite to assist them, in addition to the AT&T Language Line. Members who need translation services are directed to call the Member Services Department for assistance.

Element 3.8 – MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is met.

The Translation Services Policy describes VPHP's use of the Virginia Relay Center (VRC) to provide information to members in alternative formats. The Member Handbook provides a toll-free telephone

number for members to contact VRC to receive oral translation of materials if they are visually impaired and TTY/TDD services if they are hearing impaired.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26 (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 – MCO has a confidentiality agreement in place with providers who have access to PHI.
This element is met.

Confidentiality of protected health information (PHI) is addressed in VPHP's provider contracts. The contracts require that providers implement and maintain procedures for maintaining and safeguarding the confidentiality of member medical records and treatment in accordance with all Federal and State laws.

Element 4.2 – The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).
This element is met.

VPHP has multiple policies that describe the MCO's safeguards for preventing the use and disclosure of PHI. These include the Health Information Privacy Policy, the Administrative Practices: The Privacy Rule Policy, and the Administrative, Physical, and Technical Safeguards Policy.

Element 4.3 – The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.
This element is met.

The Minimum Necessary Policy describes the VPHP's procedures for making member PHI available to the DMAS within 30 days of an individual's request for such information as notified and in the format requested by the Department.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).

Element 5.1 – MCO has policies and procedures in place that define emergency and post-stabilization situations that describe what to do in an emergency. The Member Handbook supplies a telephone number and instructions for obtaining advice on getting care in an emergency, and states that prior authorization is not needed.
This element is met.

The Emergency Department Appropriateness Criteria Policy states that emergency care does not require preauthorization in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. The policy states that emergency care is reviewed post-service to ensure it was medically necessary. VPHP covers emergency room visits authorized by the member's PCP or other authorized MCO representatives.

The Member Handbook defines what constitutes an emergency and instructs members on what to do in cases of emergency, including calling their PCPs, 911, or the VPHP Nurseline.

Element 5.2– MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is met.

The Member Handbook provides information to members regarding the use of after-hours medical services, including VPHP's Nurseline, which is available from 5:00 p.m. to 8:00 a.m. Monday through Friday and 24 hours a day on weekends. The MCO maintains a toll-free telephone number for the

Nurseline, which is provided in the Member Handbook and on members' ID cards.

Element 5.3 – MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is met.

The Member Handbook defines what constitutes an emergency and instructs members on what to do in cases of emergency, including calling their PCPs, 911, or the VPHP Nurseline.

Element 5.4 – MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation. (Medical HelpLine Access).
This element is met.

The Member Handbook indicates that VPHP provides transportation to emergency and non-emergency visits for covered services. Non-emergency transportation includes VPHP vans, taxicabs, registered drivers, wheelchair vans, and public transportation, which can be arranged by contacting the Member Services Department. Emergency transportation can be arranged by calling 911.

Element 5.5 – MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is met.

The Provider Directory, which members receive upon enrollment, identifies the VPHP network hospitals that provide emergency and post-stabilization services.

ER6. Advance Directives.

Element 6.1 – The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is met.

The Member Handbook provides information to members regarding advance directives. The information indicates that VPHP members 18 years old or older have the right to decide what care they do or do not want, if they are unable to make their wishes known in the future. Members also have the right to choose someone to act on their behalf and make health care decisions if they are unable to do so. The summary provides specific information regarding living wills and durable powers of attorney for health care.

Element 6.2– MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is met.

The Member Rights and Responsibilities statement, documented in the Member Rights Policy and published in the Member Handbook, includes the right of members to participate in the decision-making process with their doctors regarding their health care.

Element 6.3– Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is met.

The Member Rights and Responsibilities statement, documented in the Member Rights Policy and published in the Member Handbook, includes the right of members to have their doctor discuss treatment alternatives and all appropriate treatment options available regardless of the cost or benefit coverage.

This is the "right to", but what about "procedures to" communicate. The procedures are communicated in the Member Rights Policy.

Element 6.4 – MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is met.

VPHP's UM Program Description and Open Access to Family Planning Policy include language indicating that members may self-refer for family planning services from in- or out-of-network providers, OB/GYN care, and annual mammograms. Language reflecting this policy was found in the Member Handbook.

Element 6.5 – MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is met.

The Member Rights for a Second Opinion Policy indicates that VPHP allows coverage at no cost to the member for a second opinion by a provider of the same or similar specialty as the treating provider when requested by the provider, member, or member's representative. The Member Rights Policy also includes the right of members to obtain a second opinion. These policies are communicated to members in the MCO's Member Handbook.

ER7. Rehabilitation Act, ADA.

Element 7.1 – MCO is in compliance with Federal and State laws regarding enrollee confidentiality.
This element is met.

The Notice of Privacy Practices Policy describes the procedures in place to ensure member privacy and confidentiality. The notice explains how member's health care information is used or disclosed for treatment, payment or health care operations, and for other purposes that are permitted or required by State or Federal law. The notice also describes members' rights to access and control their PHI. Member confidentiality is addressed further in the Health Information Privacy Policy, the Administrative Practices: The Privacy Rule Policy, and the Administrative, Physical, and Technical Safeguards Policy.

Element 7.2 – MCO has provided the enrollee with a description of their confidentiality policies.
This element is met.

The Notice of Privacy Practices is distributed to members upon enrollment in their new member packets. VPHP also includes information regarding the MCO's confidentiality policies in the Member Handbook.

Element 7.3 – MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is met.

The Member Handbook provides information to members on how to obtain copies of their medical records and how to request records from the MCO. VPHP's Member Services Department assists members in receiving their medical records within 10 days of request.

QA1. 438.206 Availability of services (b).

Element 1.1 – – MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:

- Network Provider Composition
- Provider Enrollment into Medicaid
- Network Provider Licensing and Certification Standards
- Enrollee to PCP ratios
- Specialist Services
- Enrollee to Dentist Ratios
- Inpatient Hospital Access
- Policy of Nondiscrimination
- Twenty-four hour coverage
- Travel Time and Distance
- Appointment Standards
- Emergency Services Coverage – provider contracts
- Monitoring/Corrective Action

This element is met.

The content of the following documents provide evidence that the MCO has policies and procedures to maintain and monitor a network of appropriate health care providers, supported by written agreements that is sufficient to provide adequate access to all of the services covered under the contract.

- In the 2005 Credentialing Program Description in the section, Standards of Participation for Professional Practitioners, it is stated that VPHP accepts professional practitioners into its network based on the need for practitioners in certain specialties and geographic areas and that PCPs must meet minimum standards for participation in the VPHP network, including having in place an acceptable 24-hour coverage system.

- The policy Oversight of Network Adequacy describes VPHP's system for ensuring that network providers are in compliance with DMAS access standards. The Network Development Committee oversees monthly monitoring as well as the corrective action plans implemented to correct access deficiencies. Specialty and PCP GeoAccess data for 2005 were made available for review.

The Requirements for Maintaining Network Adequacy Policy discusses the DMAS standards and how the MCO maintains an adequate network of providers as required by DMAS contract, based on Medicaid/FAMIS Plus enrollment. Per the policy the MCO considers "geographic location of providers

and enrollees . . . considering distance and travel time. . . . Cultural, ethnicity, language, & other special needs of the member population being served" when assessing network adequacy.

Element 1.2 – MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is met.

Per the Specialist as Primary Care Physician Policy, VPHP allows members with disabling conditions or chronic illnesses to request that their specialist serve as their PCP.

QA2. 438.206 Availability of Services (b)(2).

Element 2.1 – MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is met.

Per the Member Handbook 2005, page 37, the MCO explains to enrollees that women's health services can be obtained without a referral.

QA3. 438.206 Availability of Services (b)(3).

Element 3.1 – MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

Per the policy Member Rights For A Second Opinion, VPHP authorizes a second opinion at no cost to the member, when requested by a provider, member, or member's representative, , from a provider of the same or similar specialty as the treating provider.

QA4. 438.206 Availability of Services (b) (4).

Element 4.1 – MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is met.

The Routine Care Out of Service Area or Out of Network Policy and the Out of Plan Referral Policy describe how VPHP members may obtain out-of-area services. These policies and VPHP's UM Program Description indicate that the MCO's members may use non-participating providers for services with preauthorization from VPHP if network providers are unable to provide the service required, the MCO does not have a provider in the network with appropriate training or experience to provide the service, or the service was authorized by another MCO or Medicaid prior to enrollment with VPHP.

QA5. 438.206(c)(2) Cultural Considerations.

Element 5.1 – The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is met.

The Cultural Considerations Policy states that VPHP will identify member populations in which English is not the primary language. According to the policy, VPHP makes member materials available in languages other than English for populations that exceed 5% of the MCO's membership. At all other times, the MCO provides translation services to members to facilitate the exchange of information in their native tongue. The MCO reported that Spanish-speaking members currently exceed 5% of VPHP's population. Consequently, the Member Handbook and other materials have been printed in Spanish.

The Translation Services Policy states that the AT&T Language Line is used to translate and explain member materials to members in other languages, as needed. The Member Handbook informs members that VPHP has bilingual speakers on-site to assist them, in addition to the AT&T Language Line. Members who need translation services are directed to call the Member Services Department for assistance.

QA6. 438.208 Coordination and Continuity of Care.

Element 6.1 – MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.
This element is met.

The Member Transitions and Coordination of Care Policy describes VPHP's process for coordinating care of members, including those with special needs. The MCO's Case Management Department is responsible for identifying members with special needs and has specific guidelines that govern the coordination of care for those members. The procedures are described in the Case Management Department Complexity Guidelines Policy.

QA7. 438.208(c) 1-3 Coordination and Continuity Of Care – Additional Services for Enrollees with Special Health Care Needs.

Element 7.1 – The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is met.

Children with Special Health Care Needs Assessment Policy describes the process of how VPHP makes "a good faith effort" to assess all CSHCN identified/reported by DMAS within 90 days of notification that the children are receiving SSI .

QA1. 438.206 Availability of services (b).

Element 8.1 – The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is met.

The policies and procedures Reoccurring Services and Children with Special Health Care Needs permit a 12-month unlimited referral to a specialist for those members who have chronic or recurring health care needs that are best served by specialty care.

Element 8.2 – Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.
This element is met.

The policies and procedure In-Plan Referral System contains a description of the procedures by which specialty referrals may be made by PCPs.

Element 8.3 – The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is met.

The VPHP Case Management Policy explains how treatment plans are formulated and states that specialists and PCPs are involved with care plan formulation. Services are arranged on the basis of physician recommendations.

QA9. 438.208 (d) (2) (ii–iii) Referrals and Treatment Plans.

Element 9.1 – The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is partially met.

The VPHP Case Management Policy discusses how treatment plans are formulated and states that specialists and PCPs are involved with care plan formulation. Services are arranged on the basis of physician recommendations.

The policies do not address the overall time frames and the time frames of the discrete steps in the process of developing a care plan, including time frames for physician consultation and member approval, potentially allowing the entire process to fail the meet the standard of being "approved in a timely manner."

For this element to receive a met during the next review, it will be necessary for the policy/ plan to be able to demonstrate timeliness (measurable time frames). This should include the entire process from step one, identification of an appropriate case, to the final step when the care/ treatment plan is accepted by the member.

QA10. 438.208(e) Primary Care and Coordination Program.

Element 10.1 – MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is met.

The Member Transitions and Coordination of Care Policy discuss how VPHP ensures that members transitioning to or from VPHP to another health plan or program, or from one provider to another, receive uninterrupted coverage for medically necessary services.

Element 10.2 – Coordination of care across settings or transitions in care (NCQA QI-9).
Continuity and coordination between medical and behavioral health care for co-existing conditions
This element is partially met.

There is evidence of the plan's review of behavioral health care, i.e. physician satisfaction and utilization.

The MCO tracks physician satisfaction with continuity and communication between mental and somatic health care providers, as noted in a contracted Physician Satisfaction Survey done in 2005 by the Myers Group.

Per the 2005 Utilization Management Program, the Behavioral Health Program monitors behavioral health care. VPHP has an Associate Medical Director, who is a board certified psychiatrist who performs medical necessity determinations. A stated program goal is coordinating and providing quality managed behavioral healthcare services. The Quality Improvement Committee includes a behavioral health practitioner and VPHP provides care management services that include access and oversight of behavioral healthcare.

While these actions demonstrate that the MCO is aware of the importance of oversight and quantifying satisfaction with somatic/ mental health interactions, the information provided by the MCO shows no evidence of an ongoing program, working directly with these providers, to raise awareness of its importance or of actively promoting or facilitating information sharing.

To receive a determination of met in future reviews, VPHP must demonstrate coordination of care across settings or transitions in care through documentation that there is continuity and coordination between medical and behavioral health care for co-existing conditions.

Element 10.3 – MCO has policies and procedures to protect enrollee privacy while coordinating care
This element is met.

The Onsite Facility Reviews Policy discusses how Case Manager (CM)/Utilization Review Nursing Staff conduct on-site admission certification and concurrent reviews and maintain confidentiality of enrollee information. Per the policy, VPHP ensures that the member-specific information obtained during the utilization management process will be:

a) Kept confidential in accordance with applicable laws;
b) Used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment;
c) Shared only with those entities who have authority to receive such information; and
d) Shared only with those individuals who need access to such information in order to conduct utilization management and related processes
e) Virginia Premier Health Plan, Member Handbook for Medicaid Eligible Members includes a Notice of Privacy Practices. The Notice of Privacy Practices includes all of the same provisions noted in (a) through (d) above.

QA11. 438.210 (b) Coverage and Authorization of Services – Processing of Requests.

Element 11.1 – The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is met.

The policies and procedures Pre-Admission and Admission Review of Inpatient Hospitalization, Referral and Authorization Communication and Concurrent Review of Inpatient Hospitalization contain the utilization procedures for processing initial and ongoing authorization of services.

Element 11.2 – MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services and basic prenatal care.
This element is met.

The VPHP member handbook and the policies and procedures Open Access to Family Planning, Direct Access to Women's Health Specialist, Emergency and Post-Stabilization Services, and Appropriateness Criteria contain prohibitions against requiring prior authorization for emergency care, family planning services, preventive services, and basic prenatal care.

Element 11.3 – The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is met.

The policies and procedures Inter-Rater Reliability Audit Process for Case Managers, Utilization and Physician Reviewers, and Consistency Monitoring contain a description of the process whereby consistent application of utilization review criteria is measured and reported into the UM and QI structure.

Element 11.4 – The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.
This element is met.

The policies and procedures Pre-Admission and Admission Review of Inpatient Hospitalization, Referral and Authorization Communication, and Concurrent Review of Inpatient Hospitalization contain procedures whereby utilization review nurses and physicians may consult with the requesting provider about the requested service. These procedures also describe how network providers may communicate with VPHP medical directors or physician advisors.

Element 11.5 – If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is not applicable.

The policy and procedure Delegated Utilization Management Process contains a description of the procedures that VPHP will follow in the event that utilization determinations are delegated to an outside agency. Interviews with VPHP staff indicate that UM functions are not currently delegated to any outside agency.

Element 11.6 – Subcontractor's UM plan is submitted annually and upon revision.
This element is not applicable.

The policy and procedure Delegated Utilization Management Process requires that the UM plan be reviewed annually if utilization determinations are delegated to an outside agency. Interviews with VPHP staff indicate that UM functions are not currently delegated to any outside agency.

Element 11.7 – The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is met.

The policy and procedure Non-Certification/Denial of Certification requires that the physician advisor assigned to a review determination will have the appropriate clinical expertise to render such a determination.

Element 11.8 – MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is met.

The policies and procedures Pre-Admission and Admission Review of Inpatient Hospitalization, Non-Certification/Denial of Certification, and Communication and Concurrent Review of Inpatient Hospitalization require that a review determination be made within two days of the receipt of the required information.

Element 11.9 – MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is met.

The policy and procedure Code of Conduct requires that all VPHP staff refuse any illegal offers, solicitations, payment, or other remuneration to "induce referrals of the members we serve for an item of service reimbursable by a third party." Additionally, the VPHP Corporate Compliance Plan contains a statement that VPHP is contractually obligated by DMAS to establish monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing practices, and other types of fraud and program abuse such as false claims, kickbacks, physician self-referral, bribery, and improper gifts to government employees.

QA12. 438.210 (c) Coverage and Authorization of services – Notice of Adverse Action.

Element 12.1 – MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is met.

The policy and procedure Non-Certification/Denial of Certification requires that all non-certifications of requested services will include a written notice of such non-certification.

QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.

Element 13.1 – MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee request extension or MCO justifies a need for additional information.
This element is met.

The policy and procedure Appeals Process for Clinical Issues addresses the 14 calendar day time frame for authorization decisions for standard services, with a possible extension of up to 14 calendar days if the member or provider requests such extension. The notice must describe the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with the decision.

QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions.

Element 14.1 – The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.
This element is met.

The policy and procedure Non-Certification/Denial of Certification requires verbal notification of an expedited authorization determination within 24 hours of receipt of the request. The policy and procedure Appeals Process for Clinical Issues requires that notice be provided within three calendar days after receipt of the request for expedited service authorization decisions.

Element 14.2 – The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that notice be provided within three calendar days after receipt of the request for expedited service authorization decisions. VPHP may extend the three-calendar-day turnaround time by up to 14 calendar days if the member requests an extension or VPHP justifies to DMAS a need for additional information and how the extension is in the member's interest.

QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.

Element 15.1 – The MCO has written policies and procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is met.

The 2005 Credentialing Program Description contains policies and procedures for selection and retention of providers. It discusses the Standards of Participation for Professional Practitioners, ongoing credentialing and recredentialing.

Element 15.2 – MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.
This element is met.

The Quality Improvement Recredentialing Practitioner Profile Policy discusses VPHP's process for practitioner performance data to be incorporated into recredentialing files for consideration at the time of recredentialing. It includes "relevant member grievances, quality of care reviews, medical record reviews, site visits, and the results of focused quality studies." Quality grievances/complaints, including issues such as access to health care services, utilization and medical management, practitioners' care and treatment, administrative grievances, and payment and reimbursement are also collected.

Element 15.3 – MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is met.

The Termination of a Licensed Independent Provider Policy discusses how VPHP terminates providers based on failure to act in accordance with policy and procedure, standards of the MCO, and auditing and regulatory bodies, including the State and Federal government and NCQA, JCAHO, and URAC. A terminated provider will be notified of the decision and his or her appeal rights by mail. If a provider's termination is related to competence or professional conduct, the Department of Health Professionals and NPDB are notified in writing within 30 business days. An actual case from 2005 was reviewed and demonstrated that a report had been made to the NPDB by the MCO in an appropriate manner.

QA16. 438.214 (c) Provider selection – Nondiscrimination.

Element 16.1 – MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is met.

Per the Non Discrimination for Practitioners/Providers Policy, VPHP does not discriminate against any practitioner/provider on the basis of location, type of services provided, or current enrollee populations in a particular locality. VPHP's credentialing policies and procedures do not discriminate against providers who "serve high-risk populations or specialize in conditions that require costly treatment."

QA17. 438.12 (a,b) Provider Discrimination Prohibited.

Element 17.1 – For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is met.

The VPHP Appeal Process and the 2006 Credentialing Program Description Exclusion Criteria address issues of competence, professional conduct, and business/administrative reasons for denying credentialing. Examples for exclusion include conflicts of interest, criminal offenses related to Medicare or Medicaid, patient abuse, or fraud. The Credentialing Committee notifies an applicant of the denial by certified mail. The notice states the reasons for the sanction to allow the practitioner to prepare evidence for an appeal.

QA18. 438.214 (d) Provider Selection – Excluded Providers.

Element 18.1 – MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is met.

In the VPHP Appeal Process and the 2005 Credentialing Program Description, Exclusion Criteria, address issues of competence, professional conduct, and business/administrative reasons for denying credentialing. Examples for exclusion include conflicts of interest, criminal offenses related to Medicare or Medicaid, patient abuse, or fraud. Per the policies, Credentialing staff, at the request of the Credentialing Committee, notifies an applicant of the denial by certified mail. The notice states the reasons for the sanction to allow the practitioner to prepare evidence for an appeal. The practitioner can request an appeal hearing. Per the Credentialing Program Description, the applicant must establish that he or she meets VPHP's standards for participation.

QA19. 438.56 (b) Provider Enrollment and Disenrollment – Requested by MCO.

Element 19.1 – MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is met.

Per the Virginia Premier Health Plan, Member Handbook, "The Department of Medical Assistance Services determines your effective and termination date. . . . If you want to leave Virginia Premier, please call the Managed Care Help Line at (800) 643-2273." The MCO is precluded from disenrolling a member by DMAS requirements. Request for member disenrollment is referred to DMAS.

QA20. 438.56 (c) Provider Enrollment and Disenrollment – Requested by enrollee.

Element 20.1 – MCO has policies and procedures in place for enrollees to request disenrollment
This element is met.

The Virginia Premier Health Plan, Member Handbook provides information for disenrollment; however, the MCO may not disenroll an enrollee.

Element 20.2 – MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment 30 calendar days for each)
This element is met.

The Provider Termination and Reassignment of Members Policy discusses how VPHP deals with PCP terminations. A provider, based on the VPHP contract, is responsible to notify members 30 days prior to leaving the VPHP network. As noted in the TERMINATION section of the group provider contract, the **"**Group shall provide at least thirty (30) days prior written notice of termination to all Members who have selected or are assigned to Group."

Also per the Provider Termination and Reassignment of Members Policy, while the Provider/Group is obligated to notify members thirty (30) days prior to termination, the Enrollment department notifies members within 15 days of receipt or issuance of termination of a contracted PCP provider; and also advises them of reassignment to another PCP. They receive new member identification cards 30 calendar days prior to the provider disenrollment.

QA21. 438.228 Grievance Systems.

Element 21.1 – MCO has a process for tracking requests for covered services that were denied.
This element is met.

The policy and procedure Request Denial Process contains a description of the process for monitoring utilization determinations as well as the procedures for reporting utilization activity through the UM and QI structure.

Element 21.2 – MCO has process for fair hearing notification
This element is met.

The policy and procedure Appeals Process for Clinical Issues contains a description of the State fair hearing process.

Element 21.3 – MCO has process for provider notification
This element is met.

The policies and procedures Non-Certification/Denial of Certification, Request Denial Process, Appeals Process for Clinical Issues, and Member Inquiries and Grievance Process require that providers be notified of all adverse determinations.

Element 21.4 – MCO has process for enrollee notification and adheres to state timeframes
This element is met.

The policies and procedures Non-Certification/Denial of Certification, Request Denial Process, and Appeals Process for Clinical Issues require notification to members of all review determinations. These requirements are within those contained in the Medallion II contract and those required by Federal regulations.

QA22. 438.230 Subcontractual Relationships and Delegation.

Element 22.1 – MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is met.

The Delegated Credentialing Oversight Policy is designed to "ensure accountability and oversight for credentialing and recredentialing activities of practitioners." The policy clearly specifies the process to ensure the capability to accept delegation. The responsibilities and delegated activities of the delegated entity and VPHP are clearly specified in the policy.

A pre-site delegation audit is conducted before a delegation agreement is entered into. A template for a pre-site delegation audit review is included in this policy.

The audit includes a:

- Site visit.
- Medical Record Review.
- Written review of the delegate's understanding of the standards.
- Review of the delegated tasks, staffing capabilities and performance records.

Element 22.2 – MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is met.

The Agreement for Delegated Credentialing was reviewed and reflects all of the elements that were discussed in the delegated credentialing policy.

The Delegated Credentialing Oversight Policy is designed to "ensure accountability and oversight for credentialing and recredentialing activities of practitioners (to include behavioral health), if VPHP delegates all or part of these activities". The MCO uses nationally recognized standards such as NCQA and URAC. Annual audits occur subsequently if the delegate is not NCQA-certified or NCQA-accredited. The specifics of the annual review are found in the policy. Delegated credentialing is also addressed in the 2005 Credentialing Program Description

Element 22.3 – MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is met.

The Delegated Credentialing Oversight Policy is designed to "ensure accountability and oversight." Delegated oversight includes performing annual file audits to assess compliance with VPHP, NCQA, and URAC standards. Corrective action plans are required if deficiencies are identified. If issues are unresolved the delegation may be revoked

Element 22.4 – MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is met.

Per discussions with VPHP staff, only credentialing is delegated at this time. The delegates must follow the standards of VPHP (including those that involve reporting providers and the actions that would seriously impact quality of care or that may result in suspension/termination of participation and subsequent notification to National Practitioner Data Bank (NPDB)

QA23. 438.236 (a, b) Practice Guidelines.

Element 23.1 – The MCO has adopted practice guidelines that meet current NCQA standards and the following:
This element is met.

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is met.

The Clinical Practice Guidelines Policy describes the basis of new guidelines to include:

- Review of VPHP's membership data (i.e., focusing on issues relevant to the MCO's population).
- Review of clinical practice patterns including variation in practice patterns based on the MCO's precertification experience
- Prevention and Wellness Protocols.
- Review of claims codes or pharmaceutical usage.
- The MCO's experience in the areas of quality and utilization management.

The Clinical Practice Guidelines Policy discusses the origin of the guidelines. Sources include:

- National evidence-based guidelines, including those available through the National Guidelines Clearinghouse
- Professional medical associations
- Voluntary health organizations
- Governmental institutes, including NIH

b) Consider the needs of the enrollees.
This component is met.

The Clinical Practice Guidelines Policy describes how new guidelines are based on review of VPHP's data (i.e., focusing on issues that are relevant to the MCO's population).

c) Are adopted in consultation with contracting health care professionals, and
This component is met.

Per the Clinical Practice Guidelines Policy, practitioners on the Medical Management Committee (consisting of physicians from academia and the network) who have expertise in a specific subject area are involved with developing draft guidelines. VPHP practitioners participate in guideline review based on their participation in committees, collaborative activities, and feedback from providers to whom guidelines have been distributed.

d) Are reviewed and updated periodically, as appropriate.
This component is met.

Per the Clinical Practice Guidelines Policy, a formal review of a guideline occurs every two years. If new information is noted before that time that would necessitate review of the guideline, the guideline may be revised before two years.

QA24. 438.236 (c) Dissemination of Practice Guidelines.

Element 24.1 – The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is met.

Guidelines are distributed to appropriate VPHP staff and practitioners (i.e., those who are likely to use the guideline) for use in direct patient care. Distribution of the guidelines could be in one or more of the following:

- New practitioner orientation materials.

- Practitioner manuals.
- Newsletters.
- Special mailings to affected practitioners.
- Internet – VPHP web page.

A paper copy of the clinical practice guidelines is available upon request.

Per the Clinical Practice Guidelines Policy, the guideline is circulated to all appropriate providers. The May 2005 Member Newsletter states that practice guidelines are available from the Member Services Department.

QA25. 438.236 (d) Application of Practice Guidelines.

Element 25.1 – MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is met.

The Clinical Practice Guidelines Policy discusses how MCO decisions regarding utilization review criteria, case management guidelines, and member education information are reviewed and are modified to ensure that they are congruent with the MCO's guidelines.

QA26. 438.240 Quality Assessment and Performance Improvement Program.

Element 26.1 – MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is met.

The 2005 Quality Improvement Evaluation and the 2005 Quality Improvement Program Description demonstrate that VPHP has an active, ongoing quality assessment and performance improvement program. The Quality Improvement Program activities include "data collection, trending, establishment of baseline measurements, monitoring, measuring and evaluating aspects of quality care and service." The program collects information that facilitates continual improvement of care and services provided through VPHP practitioners. The priorities for selection of initiatives are based on population analysis.

Element 26.2 – MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is met.

The Quality Control in Asthma Management QIP is expected over time to result in demonstrable and sustained improvement in significant aspects of clinical care. Actions taken to date would be expected to have an impact in improving care for asthmatics. Project progress is monitored through the quality improvement channels.

Element 26.3 – The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is met.

The Quality of Care/Service Grievance Investigation Policy demonstrates how VPHP identifies and implements investigations of member and practitioner grievances related to quality issues, including quality of care or services. It explains how the QMC receives the grievance, determines what information is needed for an investigation, reviews the information, makes a decision, and takes action based on appropriate review, considering the severity of the issue. Follow-up is conducted as needed.

QA27. 438.240 (b) (2) Basic Elements of QAPI Program – Under/Over Utilization of Services.

Element 27.1 – MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is met.

The 2005 Quality Improvement Evaluation addresses both underutilization and overutilization of the Medallion II services in areas including:

- Mental health utilization, length of stay.
- Acute inpatient care.
- Outpatient drug utilization.

QA28. 438.240 (b) (3) Basic Elements of QAPI Program – Care Furnished to Enrollees with Special Health Needs.

Element 28.1 – MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is met.

The Children with Special Health Care Needs Assessment Policy describes case management services that are provided to this population. The MCO conducts an assessment of CSHCN in a timely manner upon notification. A case manager will work in collaboration with the member, parents, health care providers, school systems, and community agencies to coordinate care for the member.

The case manager will attempt contact with each identified CSHCN member at least semi-annually or more frequently, based on the clinical circumstances, to reassess the member's needs. CSHCN members with ongoing needs for specialty care are provided with a referral for a minimum of one year, with unlimited visits. VPHP works with local and regional Care Connection for Children agencies to make referrals and coordinate care.

VPHP oversees access to providers who are experienced in serving CSHCN by assessing the provider network at least annually.

QA29. 438.242 Health/Management Information systems.

Element 29.1 – The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is met

The Aggregate Data and Information Standards Policy explains how the MCO uses a number of computer systems to furnish timely, accurate, and complete information. Information sources on the system include claims, utilization management, newborn additions, and other information and reports required under the DMAS contract. The system comprises the IDX® Data Base Management System (DBMS), Microsoft® Office Professional Suite, Cognos® Business Solutions, and IDX® standard reporting tools. The MCO uses these tools to collect and aggregate data used in managerial and administrative decisions, operations, and activities involving member care and performance improvement.

Element 29.2 – The MCO information system is capable of:

a) Accepting and processing enrollment reports.
b) Reconciling reports with MCO enrollment/eligibility files.
c) Accepting and processing provider claims and encounter data.
d) Tracking provider network composition, access to services, grievances and appeals.
e) Performing QI activities.

This element is met.

The Policy IDX Dictionary 471 discusses how VPHP maintains a data warehouse of vendor/ provider data in order to ensure accurate claims payment.

The Aggregate Data and Information Standards Policy explains how VPHP uses computer report tools and other management and reporting software to define and capture aggregate data used for executive and day-to-day decision making, operations, member care, and performance improvement activities.

Reports include:

- Claims lag reports.
- Claim reports and extract.
- Utilization management reports.
- Hospital disproportionate reports.
- Newborn statistical reports.

The Claim Forms – Guidelines for Filing document contains information explaining the process for filing claims so as to supply all required information.

Oversight of Network Adequacy Policy discusses VPHP's system for ensuring compliance with the DMAS access standards. The adequacy of the network is evaluated monthly by the Network Development Committee. Plans are implemented to correct deficiencies.

The VPHP Standard Operating Procedure – Encounter Data Completeness Plan discusses the process used by the MCO to ensure claims/encounters submitted to DMAS are timely and accurate.

The Member Inquiries and Grievance Processes Policy discusses how the MCO uses the IDX Customer Service Module to document and track issues and inquiries presented through contact with members, practitioners and providers including those related to grievances and appeals.

The 2005 Quality Improvement Program Description details information that is collected via the computer systems for quality improvement purposes.

Element 29.3 – Furnishing DMAS with timely, accurate and complete clinical and administrative information.
This element is met

The VPHP Standard Operating Procedure – Encounter Data Completeness Plan defines the process used to ensure the accuracy of all claims/encounters submitted to DMAS. Encounters are validated to meet industry standards. Any file that fails to meet standards is evaluated, corrected, and resubmitted until it passes compliance testing. Encounters are compiled for VPHP claims and/or received by its subcontractors on a monthly basis.

Element 29.4 – MCO ensures that data submitted by providers is accurate by:

a) Verifying the accuracy and timeliness of reported data.
b) Screening the data for completeness, logic and consistency

c) Collecting service information in standard formats for DMAS
d) Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to MCO.

This element is met.

The Claim Forms – Guidelines for Filing document contains information explaining the process for filling claims containing all required information

IDX Dictionary Policy 471 explains how a data warehouse of vendor data is maintained to provide adequate information for analysis of collected data.

The VPHP Standard Operating Procedure – Encounter Data Completeness Plan defines the process to ensure the accuracy of all claims/encounters submitted to DMAS. Encounters are validated to meet industry standards. Any file that fails to meet standards is evaluated, corrected, and resubmitted until it passes compliance testing. Encounters are compiled for VPHP claims and/or received by its subcontractors on a monthly basis.

Element 29.5 – MCO uses encryption processes to send PHI over the internet
This element is met.

VPHP uses a Secure Remote Connection to the Virginia Commonwealth University Health System (VCUHS) network, using dial-up and virtual private network services, and has an automatically generated password/PIN combination. The MCO follows the established guidelines of VCUHS.

GS1. 438.402 (a, b) Grievance System.

Element 1.1 – MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process include a description of the appeals and grievance processes.

Element 1.2 – The definitions for grievances and appeals are consistent with those established by the state 7/03.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process include the definitions of grievances and appeals and they are consistent with the definitions in the Medallion II contract.

Element 1.3 – Policy and procedure describes how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is met.

VPHP limits services to the FAMIS and Medallion II population and does not provide commercial managed care services. Therefore, all inquiries, grievances, and appeals for the Medallion II program are strictly for this population.

Element 1.4 – Policy and procedure describes how MCO responds to grievances and appeals in a timely manner.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process contains a description of the procedures employed to respond to grievances and appeals in a timely manner. The time frames described in the procedures are within the requirements of the Medallion II contract as well as within the periods required by Federal regulation.

Element 1.5 – Policy and procedure describes the documentation process and actions taken.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process contain a description of the required documentation for an appeal or grievance as well as the required action to be taken for appeals and grievances.

Element 1.6 – Policy and procedure describes the aggregation and analysis of the data and use in QI.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process include provisions for analyzing and reporting grievance and appeals activity through the QI structure for improvement activities and compliance monitoring. Evidence of review of the appeals and grievance trends was present in the QIC minutes

Element 1.7 – The procedures and any changes to the policy and procedure must be submitted to the DMAS annually.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process require that the policies be submitted to the State of Virginia Department of Medical Assistance Services (DMAS) annually, for review and approval. Approved policy was provided for review

Element 1.8 – MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is met.

Information regarding grievances and appeals is made available to participating providers through provider newsletters and though participation agreements. Contracts for delegated services include a description of the requirements for appeals and grievances that subcontractors are subject to.

GS2. 438.402 (3) Filing Requirements – Procedures.

Element 2.1 – The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process include a copy of the grievance/appeal form that is provided to members upon notice of adverse action and instructions and telephone numbers to contact the VPHP Member Services Department for assistance with filing the appeal or grievance.

Element 2.2 – The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is met.

The Medallion II and FAMIS Member Handbooks include a statement that assistance with filing an appeal or grievance is available. This assistance includes translation services and TTY/TDD services.

GS3. 438.404 Notice of Action.

Element 3.1 – Notice of action is written according to language and format requirements set forth in GS. 438.10 Information Requirements.
This element is met.

The notice of action was reviewed by DMAS and approved as compliant with contractual readability requirements.

GS4. 438.404 (b) Content of Notice of Action.

Content of NOA explains all of the following:

Element 4.1 – The action taken and reasons for the action.
This element is met.

Each of ten notices of action reviewed contained a description of the action taken and the reason for the action. The policy and procedure Appeals Process for Clinical Issues contains a list of the required elements of a notice of action. The action taken and the reason for the action are required elements.

Element 4.2 – The enrollee's right to file an appeal with MCO
This element is met.

Each of ten notices of action reviewed contained a statement describing the enrollees' right to appeal to the MCO. The policy and procedure Appeals Process for Clinical Issues contains a list of the required elements of a notice of action. The right to appeal to the MCO is listed

Element 4.3 – The enrollee's right to request a State fair hearing.
This element is met.

Thirty notices of action were reviewed. The notices did not consistently include a description of the members' right to request a State fair hearing. Six of 30 files did not provide a description of the right to file an appeal with DMAS. These files were identified as FAMIS enrollees, who, per the FAMIS contract, are not afforded the State fair hearing process and are instead given access to external review of their appeals following the VPHP appeal process.

The policy and procedure Appeals Process for Clinical Issues contains a list of the required elements of a notice of action. The enrollees' rights to request a State fair hearing or appeal to an external review organization are listed.

Element 4.4 – The procedures for exercising appeal rights.
This element is met.

Each of ten notices reviewed contained a description of the procedure for exercising appeal rights. The policy and procedure Appeals Process for Clinical Issues contains a list of the required elements of a notice of action. The procedures for exercising appeal rights are listed.

Element 4.5 – The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is met.

Each of ten notices reviewed contained a description of the procedure for expedited appeal rights. The policy and procedure Appeals Process for Clinical Issues contains a list of the required elements of a notice of action. The procedures for expedited appeals are listed.

Element 4.6 – The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is unmet.

Thirty notices of action were reviewed. These notices did not contain a statement that identified the members' right to request that benefits be continued while the appeal resolution was pending or that the member may be held liable for the cost of services if the appeal outcome is unfavorable.

The policy and procedure Appeals Process for Clinical Issues contains a list of the required elements of a notice of action. The requirements to notify members of their right to request that benefits be continued during the period of the appeal resolution and to advise members that they may be liable for the cost of those services if the appeal resolution is unfavorable are included in the list of required elements.

In order to receive a finding of met in future reviews, VPHP must include a statement, in the notice of action, that identified the members' right to request that benefits be continued while the appeal resolution was pending or that the member may be held liable for the cost of services if the appeal outcome is unfavorable.

GS5. 438.416 Record Keeping and Reporting Requirements.

Element 5.1 – The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process include a description of the process by which appeals and the content of grievances are tracked and analyzed for QI purposes. Review of 30 appeals files revealed that a copy of the notice of action, a copy of the member appeal, and the appeal determination are maintained within the file.

GS6. 438.406 Handling of Grievances and Appeals – Special Requirements for Appeals.

Element 6.1 – MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollees' condition or disease.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process require that any reconsideration of an adverse determination or grievance decision will not be made by an individual or the subordinate of such individual who was involved in the initial determination.

Element 6.2 – MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process include a requirement that all inquiries that are appeals or grievances be treated as a formal submission regardless of the medium of communication. All verbal inquiries will be accepted and must be confirmed in writing.

Element 6.3 – MCO provides enrollee with reasonable opportunity to present evidence and allegations of the fact or law in person, as well as in writing.
This element is partially met.

The policy and procedure Appeals Process for Clinical Issues requires and the Member Handbook includes instructions for filing an appeal that include the member's ability to present evidence and allegations of fact or law in person as well as in writing within five days of filing the appeal.

Thirty notices of action were reviewed and 12 did not include a statement that the enrollee has an opportunity to submit additional information.

Discussion with staff revealed that the template for the notices that did not include a statement describing the right to submit additional information during the course of an appeal was modified mid-year 2005. Review of the dates of notices confirmed that all letters identified as lacking information regarding the submission of additional information were written during the first half of 2005.

In order to receive a finding of 'met', the notice of action must include a statement that a member or the member's designated representative will be permitted a reasonable opportunity to present evidence and allegations of the fact or law in person, as well as in writing.

Element 6.4 – MCO informs enrollee of limited time available for cases of expedited resolution.
This element is partially met.

The policy and procedure Appeals Process for Clinical Issues requires that expedited appeals will not exceed three calendar days from the initial receipt of the appeal. The Member Handbook contains a description of the procedures for expedited appeals as well as the limited time available for filing an expedited appeal.

Eight of 30 notices reviewed did not contain a description of the limited time available for expedited appeals.

Discussion with staff revealed that the template for the notices that did not include expedited appeal rights was modified mid-year 2005. Review of the dates of notices indicate that all letters that were identified as lacking information regarding expedited appeals were written during the first half of 2005.

In order to receive a determination of met in future reviews, VPHP must ensure that the current version of the notice of action, which includes the limited time available for cases of expedited resolution, must be used to be in compliance with this element.

Element 6.5 – MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that an enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, be permitted to examine the enrollee case file, including medical records, considered during the appeal process

Element 6.6 – MCO continues benefits while appeal or state fair hearing is pending.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that benefits may be continued if the following criteria are met:

- The member or the provider on behalf of the member files the appeal within 10 days of the date on which VPHP mailed the notice of adverse action or prior to the effective date of VPHP's notice of adverse action; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
- The services were ordered by an authorized provider; and
- The original period covered by the initial authorization has not expired; and
- The member requests extension of benefits.

GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution.

Element 7.1 – MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires—not exceeding 30 days from initial date of receipt of the appeal.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that all standard appeals will be resolved within 30 days of the receipt of the appeal.

Element 7.2 – In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that written notice be made to the member and provider if an appeal determination is not made within 30 days. VPHP must provide information to the member to show that the additional time required to make the determination is in the interest of the member.

GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals.

Element 8.1 – MCO has an expedited appeal process
This element is met.

The policy and procedure Appeals Process for Clinical Issues contains a description of the expedited appeals process as it is outlined in the Medallion II contract.

Element 8.2 – The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that verbal notification of expedited appeal determinations be rendered as soon as possible with written notification to follow no later than two days following the verbal notification. Notification must occur within three days of the request for an expedited appeal.

Element 8.3 – MCO has a process for extension, and for notifying enrollee of reason for delay.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that VPHP notify the member and provider when an extension of the three-day expedited appeal period is needed. The extension must be in the interest of the member and may not exceed 14 days.

Element 8.4 – MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow up within two calendar days with a written notice of action.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that verbal notification of expedited appeal determinations be rendered as soon as possible, with written notification to follow no

later than two days following the verbal notification. Notification must occur within three days of the request for an expedited appeal.

GS9. 438.408 (b–d) Resolution and Notification.

Element 9.1 – MCO decisions to expedited appeals are in writing and include decision and date of decision.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that notification of expedited appeal determinations must be made in writing within three days of the determination and must include the decision and the date of decision.

Element 9.2 – For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is met.

The policy and procedure Appeals Process for Clinical Issues includes a requirement that an enrollee has a right to request a State fair hearing upon receipt of an adverse determination notice and requires that benefits may be continued during the process of an appeal if the following criteria are met:

- The member or the provider on behalf of the member files the appeal within 10 days of the date on which VPHP mailed the notice of adverse action or prior to the effective date of VPHP's notice of adverse action; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
- The services were ordered by an authorized provider; and
- The original period covered by the initial authorization has not expired; and
- The member requests extension of benefits.

Element 9.3 – MCO gives enrollee oral notice of denial and follows up within 2 calendar days with written notice.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that verbal notification of expedited appeal determinations be rendered as soon as possible with written notification to follow no

later than two days following the verbal notification. Notification must occur within three days of the request for an expedited appeal.

GS10. 438.408 (c) Requirements for State Fair Hearings.

Element 10.1 – MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is met.

The policy and procedure Appeals Process for Clinical Issues contains the requirement that appeals to DMAS for State fair hearings must be received within 30 days of the receipt of the notice of action.

The policy and procedure Appeals Process for Clinical Issues includes a provision that FAMIS members may file an appeal with Delmarva Foundation, Inc., DMAS's external review organization, once the FAMIS member has exercised his/her appeal rights through VPHP. FAMIS members must submit their appeal through DMAS and not directly to Delmarva.

Element 10.2 – MCO provides state with a summary describing basis for denial and for appeal.
This element is met.

The policies and procedures Appeals Process for Clinical Issues and Member Inquiries and Grievance Process require that appeal and grievance data be transmitted to DMAS as outlined in the Medallion II contract. Evidence of the appeal summary was present in 30 of the appeals files reviewed.

Element 10.3 – MCO faxes appeal summaries to state in expedited appeal cases.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that a summary of an expedited appeal must be faxed to DMAS within four business hours of receipt.

GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions.

Element 11.1 – The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or a State Fair Hearing reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that, in cases where the initial adverse determination was overturned, VPHP will promptly authorize the disputed services with a written notification to the member, his or her representative, and DMAS.

Element 11.2– MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division
This element is met.

The policy and procedure Appeals Process for Clinical Issues requires that, in cases where the initial adverse determination was overturned VPHP will promptly authorize payment for the disputed services with a written notification to the member, his or her representative, and DMAS.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1 & 2	Member Rights and Responsibilities Policy	03/25/2005
	VPHP Member Handbook	09/2005
	Routine Care Out of Service Area or Out of Network Policy	05/20/2004
	Changing Primary Care Physician Policy	10/01/2005
	In Plan Referral System Policy	10/01/2005
	Out of Plan Referrals Policy	10/01/2005
	Information Distribution Policy	10/01/2005
	Member Inquiries and Grievance Processes Policy	05/05/2005
	Appeals Process for Clinical Issues Policy	10/01/2005
	MCO Insolvency and/or Contract Termination Policy	05/24/2004
ER 3	Cultural Considerations Policy	05/25/2005
	Flesch Readability Formula Testing Policy	05/23/2005
	Translation Services Policy	03/25/2005
ER 4	Health Information Privacy Policy	10/01/2005
	Administrative Practices: The Privacy Rule Policy	10/01/2005
	Administrative, Physical, and Technical Safeguards Policy	10/01/2005
	Minimum Necessary Policy	12/15/2005
ER 5	Emergency Department Appropriateness Criteria Policy	08/16/2005
	VPHP Provider Directory	2005
ER 6	VPHP UM Program Description	2005
	Open Access to Family Planning Policy	05/21/2004
	Member Rights for a Second Opinion Policy	05/24/2004
ER 7	Notice of Privacy Practices Policy	09/15/2005
	VPHP Notice of Privacy Practices	07/15/2005
QA 1.1	2005 Credentialing Program Description	2005
	Oversight of Network Adequacy Policy	12/01/2005
	Oversight of Network Adequacy Policy	12/01/2005
	Requirements for Maintaining Network Adequacy Policy	10/01/2005
QA 1.2	Specialist as Primary Care Physician Policy	7/01/2003
QA 2.1	Member Handbook 2005	9/2005
QA 3.1	Member Rights For A Second Opinion	5/24/2005
QA 4	Routine Care Out of Service Area or Out of Network Policy	05/20/2004
	Out of Plan Referrals Policy	10/01/2005
QA 5	Cultural Considerations Policy	05/25/2005
	Translation Services Policy	03/25/2005
QA 6	Member Transitions and Coordination of Care Policy	10/01/2005
	Case Management Department Complexity Guidelines Policy	10/01/2005
QA 7.1	Children With Special Health Care Needs Assessment Policy	1/15/2004
QA 8.3	VPHP Case Management Policy	10/01/2005
QA 8	Reoccurring Services	10/01/2005
QA 8	Children with Special Health Care Needs	01/15/2006
QA 8	In-Plan Referral System	10/01/2005
QA 9.1	VPHP Case Management Policy	10/01/2005
QA 10.1	Member Transitions and Coordination of Care Policy,	9/15/03
QA 10.2	2006 Utilization Management Program description	2006
	Physician Satisfaction Survey done in 2005.	2005
QA 10.3	Onsite Facility Reviews Policy	9/2005
	Virginia Premier Health Plan, Member Handbook for Medicaid Eligible Members	9/2005
QA 11	Admission Review of Inpatient Hospitalization, Referral	10/01/2005
QA 11	Authorization Communication and Concurrent review of Inpatient Hospitalization	12/01/2005
QA 11	Open Access to Family Planning	01/06/2006

Summary of Documents Reviewed		
Element	**Document**	**Date**
QA 11	Direct Access to Women's Health Specialist	01/06/2006
QA 11	Emergency and Post-Stabilization Services, and Appropriateness Criteria	01/06/2006
QA 11	Inter-Rater Reliability Audit Process for Case Managers	01/30/2006
QA 11	Utilization and Physician Reviewers	01/30/2006
QA 11	Consistency Monitoring	10/01/2005
QA 11	Delegated Utilization Management Process	2005
QA 11	Non-Certification/Denial of Certification	01/30/2006
QA 15.1	Credentialing Program Description 2004	2004
QA 15.2	Quality Improvement Recredentialing Practitioner Profile Policy	1/11/2005
QA 15.3	Termination of a Licensed Independent Provider	10/01/2005
QA 16.1	Non Discrimination For Practitioners/Providers Policy	12/01/2005
QA 17.1	VPHP Appeal Process	10/01/2005
	2006 Credentialing Program Description	12/2005
QA 18.1	VPHP Appeal Process	10/01/2005
	2005 Credentialing Program Description Exclusion Criteria	2005
QA 19.1	Virginia Premier Health Plan, Member Handbook	09/2005
QA 20.1	The Virginia Premier Health Plan, Member Handbook	09/2005
QA 20.2	Provider Termination And Reassignment Of Members Policy	12/15/2005
QA 21	Code of Conduct	Undated
QA 21	VPHP Corporate Compliance Plan	Undated
QA 21	Appeals Process for Clinical Issues	1/10/2006
QA 21	Request Denial Process	10/01/2005
QA 22.1	Delegated Credentialing Oversight Policy	1/26/2005
QA 22.2	Agreement For Delegated Credentialing	Undated
	Delegated Credentialing Oversight Policy	1/26/2005
	2005 Credentialing Program Description	2005
QA 22.3	Delegated Credentialing Oversight Policy	1/26/2005
QA 23.1	Clinical Practice Guidelines Policy	12/15/2005
QA 24.1	Clinical Practice Guidelines Policy	12/15/2005
QA 25.1	Clinical Practice Guidelines Policy	12/15/2005
QA 26.1	2005 Quality Improvement Evaluation	2005
	2005 Quality Improvement Program Description	2005
QA 26.2	Quality Control in Asthma Management QIP	N/A
QA 26.3	Quality of Care/Service Grievance Investigation	12/15/2005
QA 27.1	2005 Quality Improvement Evaluation	2005
QA 28.1	Children With Special Health Care Needs Assessment Policy	1/15/2004
QA 28.1	Case Management Special Needs Assessment data collect sheet	Undated
QA 29.1	Aggregate Data And Information Standards	Undated
QA 29.1	Policies for Data Integrity, Collection and Accuracy	Undated
QA 29.2	Policy IDX Dictionary 471	Undated
QA 29.1	Aggregate Data And Information Standards Policy	10/01/2003
QA 29.1	The Claim Forms – Guidelines for Filing document	Undated
QA 29.1	Oversight of Network Adequacy Policy	12/01/2005
QA 29.3	VPHP Standard Operating Procedure – Encounter Data Completeness Plan	Undated
QA 29.4	Claim Forms – Guidelines for Filing document	Undated
QA 29.4	IDX Dictionary Policy 471	12/15/2005
QA 29.4	VPHP Standard Operating Procedure – Encounter Data Completeness Plan (undated)	Undated
QA 29.5	Electronic Mail Usage Policy	8/15/2005
GS 1	Appeals Process for Clinical Issues	01/10/2006
GS 5	Member Inquiries and Grievance Process	01/19/2006

Section II - Performance Improvement Projects

Introduction

As part of the annual External Quality Review (EQR), Delmarva conducted a review of Performance Improvement Projects (PIPs) submitted by each MCO contracting with the Department of Medical Assistance Services (DMAS). According to its contract with DMAS, each MCO is required to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. According to the contract, the PIPs must include the measurement of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. CMS' *Validation of PIPs* assists EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

For the current review period, calendar year (CY) 2005, the PIP validation protocols and tools established in 2003 were used. Reviewers evaluated each project submitted using the CMS validation tools. This included assessing each project across ten steps. These ten steps include:
Step 1: Review the Selected Study Topics.
Step 2: Review the Study Questions.
Step 3: Review the Selected Study Indicator(s).
Step 4: Review the Identified Study Population.
Step 5: Review Sampling Methods.
Step 6: Review the MCO's Data Collection Procedures.
Step 7: Assess the MCO's Improvement Strategies.
Step 8: Review Data Analysis and Interpretation of Study Results.
Step 9: Assess the Likelihood that Reported Improvement is Real Improvement, and
Step 10: Assess Whether the MCO has Sustained its Documented Improvement.

As Delmarva staff conducted the review, each component within a standard (step) was rated as "yes," "no," or "N/A" (not applicable). Components were then rolled up to create a determination of "met", "partially met", "unmet" or "not applicable" for each of the ten standards. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Performance Improvement Project Validation Review

Rating	Rating Methodology
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Results

This section presents an overview of the findings of the Validation Review conducted for each PIP submitted by the MCO. Each MCO's PIP was reviewed against all 27 components contained within the ten standards.

The results of the ten activities assessed for each PIP submitted by Virginia Premier Health Plan are presented in Table 2 below.

Table 2. 2005 Performance Improvement Project Review for VA Premier

Activity Number	Activity Description	Review Determination	
		Monitoring and Controlling the Management with the use of Two or More Atypical Antipsychotics	Quality Control in Asthma Management
1	Assess the Study Methodology	Met	Met
2	Review the Study Question(s)	Met	Met
3	Review the Selected Study Indicator(s)	Partially Met	Met
4	Review the Identified Study Population	Met	Met
5	Review Sampling Methods	Not Applicable	Not Applicable
6	Review Data Collection Procedures	Partially Met	Partially Met
7	Assess Improvement Strategies	Met	Met
8	Review Data Analysis and Interpretation of Study Results	Met	Met
9	Assess Whether Improvement is Real Improvement	Partially Met	Met
10	Assess Sustained Improvement	Unmet	Met

Conclusions and Recommendations

Conclusions

VA Premier Health Plan (VA PREMIER) provided two PIPs for review. These included, (1) Monitoring and Controlling the Management with the Use of Two or More Atypical Antipsychotics, and (2) Quality Control in Asthma Management. These were evaluated using the Validating Performance Improvement Projects protocol, commissioned by the Department of Health and Human Services, CMS, which allows assessment among 10 different project activities.

For the Atypical Antipsychotic Project, the MCO received a review determination of "Met" for five (5) elements, "Partially Met" for three (3) elements and Unmet for one (1) element. Activity 5, Sampling Methods, was "Not Applicable" as the entire population, not sampling, was used by the MCO for each measurement. For the Asthma Project, the MCO received a review determination of "Met" for eight (8) elements and "Partially Met" for one (1) element. None of the elements were "Unmet" for this project, while Activity 5, Sampling Methods, was "Not Applicable" as the entire population, not sampling, was used by the MCO for each measurement.

Recommendations

Based on a review of each of the two PIPs provided by the MCO, the following recommendations are made to improve the PIP process and performance.

Monitoring and Controlling the Management with the use of Two or More Atypical Antipsychotics

- Provide evidence from clinical literature to support that improvement in the selected indicators will reduce the development of diabetes and other metabolic abnormalities and result in improved health status for members.
- Qualifications of staff/personnel used to collect the data should be specified for all indicators.
- Implement targeted systematic interventions to increase the likelihood of positive results. One time reminders or letters are passive and less likely to positively impact the indicators. Efforts should be intensive and system level, and for example, focus on the education of providers, not just "distribution of guidelines."
- Strong, timely, and targeted interventions directly linked to identified barriers and opportunities for improvement should assist VA PREMIER in demonstrating sustained improvement through repeat measurements.

Quality Control in Asthma Management

- Qualifications of staff/personnel used to collect the data should be specified for all indicators.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: DMP Date of evaluation: 2/28/2006

Demographic Information
MCO/PHP Name or ID: Project Leader Name:
Telephone Number:
Name of Quality Improvement Project: VA Premier – Asthma
Dates in Study Period: to: Phase:

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	VPHP analyzed national and plan specific data to select the study topic. Analysis of VPHP data ranked asthma in the top five percent of diagnoses for all hospital admission/emergency department visits for the Medallion II population.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1 MMCD 2004
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	The PIP, over time, addresses a broad spectrum of key aspects of enrollee are and services.	QAPI RE2Q1QI A S1A2 MMCD 2004
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	HEDIS specifications and methodologies were used to determine the eligible population.	QAPI RE2Q1 QIA S1A2 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	VPHP presented a clear problem statement.	QIA S1A3 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	HEDIS specifications were used, therefore the indicators were objective, clearly defined and measurable.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	Decreased inpatient admissions, decreased emergency department visits and increased use of appropriate asthma medications have been identified as valid proxy measures for improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	VPHP clearly defined all Medicaid enrollees for all three indicators based upon HEDIS specifications.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	HEDIS specifications and methodology meet the requirements of this component for all indicators.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	N/A	VPHP did not use sampling in this study.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	N/A	VPHP did not use sampling in this study.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:	N/A		
5.3 Did the sample contain a sufficient number of enrollees?	N/A	VPHP did not use sampling in this study.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: This area of assessment was not applicable because VPHP did not use sampling in this study.			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	The data to be collected for this study was clearly specified.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data?	Y	The sources of data were claims/encounter and pharmacy data which were clearly identified.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	HEDIS specifications and methodologies were used and are audited each year.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	Y	HEDIS specifications and methodologies were used and are audited each year.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	Y	A quantitative and qualitative analysis was completed for each indicator. MY 2005 results are not in so an analysis cannot be performed.	QAPI RE5Q1.2
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Specify the qualifications of the staff/personnel used to collect the data.			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	Interventions undertaken to address causes/barriers identified through data analysis and QI processes appear to be reasonable.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3 MMCD 02-04 MMCD 99-02 MMCD 99-07
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	Y	Data for MY2005 was not collected prior to this submission, therefore results could not be presented. However, all previous submissions included accurate and clear results.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	Y	Results were not able to be presented or analyzed for this submission as data had not been collected for MY2005. However all previous analysis had meet these criteria, therefore it is expected that analysis of MY2005 will as well.	QAPI RE7Q2 QIA S1C4 QIA S2.1 MMCD 2004
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	Y	An analysis of the interventions success was included in the last submission and is expected to be included in the analysis of the MY 2005 data results once they are available.	QIA S2.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Y	HEDIS specifications were used and VPHP notes that there were no changes in methodology.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4 MMCD 2004
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	N/A	The data has not been collected for MY2005 therefore results could not be provided in this submission.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	Y	Improvement from baseline is seen throughout remeasurement year 2 and appears to have face validity, however the data for MY 2005 has not been collected.	QIA S3.2 MMCD 2004
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	Y	The Chi-square test has been performed during each measurement year to date. It is expected that it will be performed once the data for MY 2005 is available.	QIA S2.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	**Y**	Sustained improvement has been demonstrated through remeasurement year 2. It is expected that MY 2005 results will continue to improve.	QAPI RE2SQ3 QIA II, III MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths: HEDIS specifications and methodologies were used for all indicators. A clear problem statement was presented. There is evidence of statistically significant improvement for all three indicators.
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): Providers unable to identify enrollees who need assistance in managing their asthma more effectively, Enrollees lack of knowledge regarding the asthma management program, lack of continuous asthma education for enrollees, lack of application of plan guidelines related to asthma management, and lack of enrollees getting flu shots.
4. Action taken by MCO (Barrier Analysis): PCPs receive quarterly listing of enrollees with ED visits, inpatient hospital admissions, or who need appropriate asthma medication; newly identified enrollees with a asthma are sent a letter informing them of the asthma management program and contact info; quarterly communications in provider and member newsletters; partner w/ community agencies to present annual training of asthma management; and reminders to enrollees to get flu shot.
5. Recommendations for the next submission: • Specify the qualifications of the staff/personnel used to collect the data.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: JAJ Date of evaluation: 3/8/2006

Demographic Information		
MCO/PHP Name or ID: Project Leader Name:		
Telephone Number:		
Name of Quality Improvement Project:	VA Premier – Monitoring and Controlling the Management of Members Who Use Two or More Atypical Antipsychotics	
Dates in Study Period:	to:	Phase:

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	Virginia Premier Health Plan (VPHP) analyzed their data in response to a recent national finding that has linked the development of diabetes and other metabolic abnormalities with prescribed atypical antipsychotics.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1 MMCD 2004
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	The plan seeks to reduce the number of providers prescribing two or more atypical antipsychotics, as well as reduce the number of members receiving two or more atypical antipsychotics.	QAPI RE2Q1QI A S1A2 MMCD 2004
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	It appears the MCO included all eligible members in the study.	QAPI RE2Q1 QIA S1A2 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	The MCO's study question/problem statement provided a clear rationale for the study. The plan is concerned about the potential development of diabetes and other metabolic abnormalities in their members.	QIA S1A3 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	The study indicators were clearly defined and measurable.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	N	While the PIP described a recent association between the development of diabetes and other metabolic abnormalities with atypical antipsychotics, there was no evidence cited from clinical literature to support the improvement in selected indicators with improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Cite references in clinical literature supporting the association between improvements in selected indicators and changes in health status or valid proxy measures.			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	The MCO specified the population to which the study applies.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	The MCO's data collection methodology included all eligible members in the study.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	**N/A**	Sampling was not utilized.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	**N/A**	Sampling was not utilized.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:			
5.3 Did the sample contain a sufficient number of enrollees?	**N/A**	Sampling was not utilized.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: **N/A**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	The MCO's study design clerly specified the datat to be collected.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data	Y	The study design specified pharmacy data as the data source.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	Pharmacy data is collected twice a year and is analyzed once a year. Data is collected by data analysts and is audited to ensure validity and reliability.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	Y	There were no reported changes in methodology over time.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	N/A	N/A for remeasurement.	QAPI RE5Q1.2
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Describe qualifications of staff used to collect data.			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	Reasonable interventions were undertaken to address barriers identified; however, with the timing of the interventions, they were unable to impact the last measurement period.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3 MMCD 02-04 MMCD 99-02 MMCD 99-07
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	Y, N, or N/A	Comment	Cites and Similar References
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	Y	The MCO presented numerical results accurately and clearly.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	Y	The analysis identified baseline measurements and repeat measurements. A statistical analysis was completed. There were no identified factors that influenced comparability or validity.	QAPI RE7Q2 QIA S1C4 QIA S2.1 MMCD 2004
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	Y	The analysis discussed its success relative to previous measures and goals. However, it did not discuss success of follow-up activities. It does not appear that interventions were initiated after Remeasurement 1.	QIA S2.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Y	The plan used the same methodology for the baseline measurement and all remeasurements.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4 MMCD 2004
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	Y	The MCO documented quantitative improvement in several of the measures.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	N	Although improvement was docuemented in some of the indicators measured, it was not due to the interventions implemented by the MCO. There were no interventions initiated in 2005, after the first remeasurement.	QIA S3.2 MMCD 2004
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	Y	Statistical significance in improvement was demonstrated in several of the indicators.	QIA S2.3
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: As results are analyzed, barrier analyses should be completed, and interventions implemented.			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	N	The MCO did not demonstrate sustained imrpvoement over time periods.	QAPI RE2SQ3 QIA II, III MMCD 2004
Assessment Component: **Not Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Interventions that have impacted results thus far appear to be passive in nature. One time reminders or letters generally do not positively impact the indicators. Efforts should be system level, and for example, focus on the education of providers, not just "distribution of guidelines."			

Key Findings
1. Strengths:
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): There were no documented barriers in 2005. Barriers addressed in early 2006 include lack of education of providers and lack of psychiatric services in various regions of the state.
4. Action taken by MCO (Barrier Analysis): There were no implemented interventions documented in 2005.
5. Recommendations for the next submission: • Cite references in clinical literature supporting the association between improvements in selected indicators and changes in health status or valid proxy measures. Describe qualifications of staff used to collect data. As results are analyzed, barrier analyses should be completed, and interventions implemented. Interventions that have impacted results thus far appear to be passive in nature. One time reminders or letters generally do not positively impact the indicators. Efforts should be system level, and for example, focus on the education of providers, not just "distribution of guidelines."

National Committee for Quality Assurance (NCQA)

Quality Improvement Activity (QIA) Form

Activity Name: Quality Control in Asthma Management

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

Measurement Year = MY
Data Collection Year = CDY

Rationale & Internal Data Analysis: According to the 2003 NCQA State of the Health Care Quality Report (SOHC), Asthma is one of the nation's most common and costly diseases, affecting an estimated 15 million people, including 7.7 million children and adolescents. Asthma is the country's most common chronic disease in children and the sixth most common chronic condition overall. Many asthma-related hospitalizations, emergency room visits, and missed work and school days can be avoided if patients have appropriate medications and medical management. According to the Centers for Disease Control (CDC), in 2001, 20.3 million Americans had asthma, and 12 million had had an asthma attack in the previous year. If a person has a parent with asthma, he or she is three to six times more likely to develop asthma than is a person who does not have a parent with asthma. For the reasons identified in the SOHC report, Virginia Premier Health Plan, Inc. (VPHP) decided to study asthma management.

Secondly, VPHP decided to study asthma because in MY 2003, 51 Plan members with Persistent asthma were admitted to acute care facilities and 199 Plan members with Persistent asthma visited the ER. Based upon Plan data aggregated and analyzed, asthma ER visits and hospital admissions ranked in the top five percentage of all admissions and diagnoses, which further necessitated the importance of the study. The Plan re-evaluated and re-engineered its Asthma Management Program. Under the Plan, Asthma is stratified as follows: mild, moderate and severe, with appropriate and increasingly aggressive interventions at each level. In CY2005, the Plan implemented a Chronic Disease Management Program and a Department that will focus more directly on managing chronic diseases, such as asthma.

Problem Statement: Plan members do not effectively manage their asthma conditions with controller medications, as evidenced by increased acute care utilization (hospital admissions and emergency room (ER) visits), which lead to poor health status and increased health care costs.

Purpose of the Study: Test the effectiveness of interventions in an effort to improve asthma management and control costs.

Hypothesis: Uncontrolled asthma management through the inadequate use of controller medications lead to increased hospital admissions and emergency room visits.

Definition of Asthma and the HEDIS Measure: According to the Centers for Disease Control, Asthma is a disease that affects your lungs. It is the most common long-term disease of children. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. It is with you all the time, but you may have asthma attacks only when something bothers your lungs.

According to the 2004 NCQA HEDIS Technical Specifications Manual, the Use of Appropriate Medications for People with Asthma measure estimates the percentage of enrolled members 5-56 years of age who were identified as having persistent asthma and who were prescribed appropriate medication. The specification for this measure changed in 2003 to exclude certain patients who may not have asthma from the denominator. This change may be responsible for some of the increase in the measure rates. The measure is collected separately for children (ages 5-9), adolescents (ages 10-17), and adults (ages 18-56). A combined rate is also reported.

Opportunities for improvement include, but are not limited to:

Quality of Life opportunities for improvement:

According to the 2003 NCQA State of the Health Care Quality Report:

- Nearly 5000 people die from asthma each year. Some of these deaths could be prevented with improved disease management.
- Children lose an estimated 14 million school days annually because of asthma.
- Successful management of patients with moderate to severe asthma can decrease missed school and workdays.

Operational opportunities for improvement:

- Identifying contributing factors to asthma attacks is often difficult to track and monitor. Data mining of asthma data and development of an asthma data registry for further drill down analyses, will improve the process of management.
- Ability to be proactive in managing asthma for Plan members, by sending letters, pamphlets, brochures to members who are more susceptible to getting asthma due to family genetics (possibly employing some predictive modeling strategies).
- Ability to more effectively educate Plan members through face-to-face interactions.

Financial Benefits:

According to the 2003 NCQA State of the Health Care Quality Report:

- Asthma accounts for an estimated 14.5 million lost workdays for adults.
- More than 7.5 million sick days could be avoided each year if American workers with asthma had medication management rates comparable to those seen in health plans at the 90th percentile.
- The economic cost of asthma is $14.0 billion annually, including $4.6 billion in lost productivity.
- The estimated annual cost of asthma-related inpatient hospital services is over $4 billion.
- During 2000, there were 9.3 million physician office visits, 1 million hospital outpatient department visits, and 1.8 million emergency room visits for asthma.
- 45% reductions in the risk of repeat Emergency Department visits were shown in patients using inhaled corticosteroid treatment compared with nonusers.

B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.

Quantifiable Measure #1:	One or more prescriptions for cromolyn sodium, aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma
Numerator:	For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines in the measurement year. VPHP used the NDC list provided on NCQA's web site at www.ncqa.org to identify appropriate prescriptions.
Denominator:	The eligible population, which includes those individuals 5-56 by December 31 of the measurement year who are identified as having Persistent asthma using HEDIS methodology.

First measurement period dates:	January 1 – December 31, 2003
Baseline Benchmark:	64.1 (mean percentile)
Source of benchmark:	The State of Health Care Quality: 2004 Report, directed and developed by the National Committee for Quality Assurance (NCQA)
Baseline goal:	64.1 (mean percentile)
Quantifiable Measure #2:	Rate of Hospital Admissions for members with Persistent Asthma
Numerator:	Total Number of members admitted to the hospital with a primary diagnosis of asthma (ICD-9 493); All members diagnosed with emphysema (492, 506.4, 518.1, 518.2) and chronic obstructive pulmonary disease (491.2, 493.2-493.22, 496, 491.20, 491.21, 492.0, 492.8, 496, 518.1, 518.2, 506.4) were excluded from the eligible population
Denominator:	The eligible population, which includes those individuals 5-56 by December 31 of the measurement year who are identified as having Persistent asthma using HEDIS methodology.
First measurement period dates:	January 1 – December 31, 2003
Benchmark:	11.8
Source of benchmark:	Healthy People 2010
Baseline goal:	20.0
Quantifiable Measure #3:	Rate of Emergency Department (ED) Visits for members with Persistent Asthma
Numerator:	Total Number of members that were admitted to the ER with a primary diagnosis of asthma (ICD-9 493)
Denominator:	The eligible population, which includes those individuals 5-56 by December 31 of the measurement year who are identified as having Persistent asthma using HEDIS methodology.
First measurement period dates:	January 1 – December 31, 2003
Benchmark:	69.9
Source of benchmark:	Centers for Disease Control (CDC), Division of Health Care Statistics
Baseline goal:	69.9

C. Baseline Methodology.

QM #1: One or more prescriptions for cromolyn sodium, aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma – HEDIS Methodology was used for QM#1. HEDIS Methodology used in 2002 and 2003; Measure: Use of Appropriate Medications for People with Asthma

Step 1: Identified members as having persistent asthma who, during the year prior to the measurement year, had any of the following:
at least one ED visit based on visit codes with asthma (ICD-9 codes 493) as the principal diagnosis
at least one acute inpatient discharge based on the visit codes, with asthma as the principal diagnosis
at least four outpatient asthma visits based on the visit codes in the Table E14-A (Volume 2, Hedis 2004, Technical Specifications Book), with asthma as one of the listed diagnoses and at least two asthma medication dispensing events
at least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions)
Step 2: For a member identified as having persistent asthma because of at least four asthma medication dispensing events, and leukotriene modifiers were the sole asthma medication dispensed, the member must:
meet any of the other four criteria (above)
have at least one diagnosis of asthma in any setting in the year prior to the measurement year

Numerator: For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines in the measurement year. VPHP used the NDC list provided on NCQA's web site at www.ncqa.org to identify appropriate prescriptions.
Denominator: The eligible population, which includes those individuals 5-56 by December 31 of the measurement year who are identified as having Persistent asthma using HEDIS methodology.

QM #2: Rate of Hospital Admissions for members with Persistent Asthma - HEDIS Methodology was used for the denominator of QM#2 – see below:

Step 1: Identified members as having persistent asthma who, during the year prior to the measurement year, had any of the following:
at least one ED visit based on visit codes with asthma (ICD-9 codes 493) as the principal diagnosis
at least one acute inpatient discharge based on the visit codes, with asthma as the principal diagnosis
at least four outpatient asthma visits based on the visit codes in the Table E14-A (Volume 2, Hedis 2004, Technical Specifications Book), with asthma as one of the listed diagnoses and at least two asthma medication dispensing events
at least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions)
Step 2: For a member identified as having persistent asthma because of at least four asthma medication dispensing events, and leukotriene modifiers were the sole asthma medication dispensed, the member must:
meet any of the other four criteria (above)
have at least one diagnosis of asthma in any setting in the year prior to the measurement year
Step 3: For the total number of members with Persistent asthma, the number of members admitted to the hospital with a primary diagnosis of asthma (ICD-9 493) were calculated.

Numerator: For each member in the denominator, those members admitted to the hospital with a primary diagnosis of asthma (ICD-9 493)
Denominator: The eligible population, which includes those individuals 5-56 by December 31 of the measurement year who are identified as having Persistent asthma using HEDIS methodology.

QM #3: Rate of Emergency Department (ED) Visits/ 1000 members with Asthma - HEDIS Methodology was used for the denominator of QM#3 – see below:

Step 1: Identified members as having persistent asthma who, during the year prior to the measurement year, had any of the following:
at least one ED visit based on visit codes with asthma (ICD-9 codes 493) as the principal diagnosis
at least one acute inpatient discharge based on the visit codes, with asthma as the principal diagnosis
at least four outpatient asthma visits based on the visit codes in the Table E14-A (Volume 2, Hedis 2004, Technical Specifications Book), with asthma as one of the listed diagnoses and at least two asthma medication dispensing events
at least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions)
Step 2: For a member identified as having persistent asthma because of at least four asthma medication dispensing events, and leukotriene modifiers were the sole asthma medication dispensed, the member must:
meet any of the other four criteria (above)
have at least one diagnosis of asthma in any setting in the year prior to the measurement year.
Step 3: For the total number of members with Persistent asthma, the number of members admitted to the ER with a primary diagnosis of asthma (ICD-9 493) were calculated.

Numerator: For each member in the denominator, those members admitted to the ER with a primary diagnosis of asthma (ICD-9 493)
Denominator: The eligible population, which includes those individuals 5-56 by December 31 of the measurement year who are identified as having Persistent asthma using HEDIS methodology.

The data is complete to our knowledge and we plan to audit the data to ensure validity and reliability of the data. The data is collected by the Department of System Analysts using the IDX platform. Pharmacy data is obtained through an automated system. Data will be collected every year based on HEDIS methodology and will be analyzed every year. A chi-square test of statistical significance will be done comparing every remeasurement to the baseline and previous remeasurements. VPHP plans to do barrier analysis for each indicator after each measurement period and identify appropriate interventions for each indicator based upon identified opportunities for improvement. Also qualitative analysis will be done for all the indicators.

The HEDIS data has not been collected for 2005 and so the data on the three quantifiable measures are still not available for 2005.

C.1 Data Sources.

[ ] Medical/treatment records
[X] Administrative data:
[X] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[X] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):

These data sources are applicable for all data required for this study.

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____
_
_____
_

If administrative, check all that apply:
[X] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[X] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

The administrative methodology (i.e., claims, encounter and pharmacy data) was used for all three quantifiable measures and also in collecting data for both the continuous enrollment and enrollees-unduplicated, identified in the data results table (Section IV).

C.3 Sampling. If sampling was used, provide the following information. – THIS SECTION IS NOT APPLICABLE (Strictly administrative data only)

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.	Data Analysis Cycle.
[X] Once a year – QM #1, #2 and #3 [ ] Twice a year [ ] Once a season [ ] Once a quarter – [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[X] Once a year – QM #1, #2 and #3 [ ] Once a season [ ] Once a quarter – [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____ _____ _____

C.5 Other Pertinent Methodological Features. Complete only if needed.

Data was collected administratively only. The hybrid method was not utilized. A NCQA Certified Hedis Vendor, Healthcare Data.com (HDC) will audit the administrative data on May 11-12, 2004. As of June 1, 2005, VPHP contracted with a biostatistician to further enhance this study.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

This section is not applicable, as there were no changes in the methodology.

Section II: Data / Results Table Complete for each quantifiable measure; add additional sections as needed.							
#1 Quantifiable Measure: One or more prescriptions for cromolyn sodium , aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma							
Time Period Measurement Covers	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**	**Statistical Test and Significance***
JAN 1 – DEC 31, 2002	***Baseline:***	155	250	62.0	57.4 (mean percentile)	57.4	Chi-square test p=0.982 Baseline to Remeasurement #1 Chi-square test Significant increase p=0.01 Remeasurement #1 to #2 Chi-square test Significant increase p=0.011 Baseline to Remeasurement #2
JAN 1 – DEC 31, 2003	Remeasurement 1:	156	252	61.9	62.7 (mean percentile)	62.7	
JAN 1 – DEC 31, 2004	Remeasurement 2:	542	768	70.6	64.1 (mean percentile)	64.1	
JAN 1 – DEC 31, 2005	Remeasurement 3:	Not available					
	Remeasurement 4:						
	Remeasurement 5:						

#2 Quantifiable Measure: Rate of Hospital Admissions for members with Persistent Asthma							
Time Period Measurement Covers	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**	**Statistical Test and Significance***
JAN 1 – DEC 31, 2002	***Baseline:*** ***Continuous Enrollment***	52	250	20.8	11.8	20.0	Chi-square test p=0.876 Baseline to Remeasurement #1
JAN 1 – DEC 31, 2003	***Remeasurement 1: Continuous Enrollment***	51	252	20.2	11.8	20.0	
JAN 1 – DEC 31, 2004	Remeasurement 2:	49	768	6.4	11.8	11.8	Chi-square test Significant decrease p=0.000 Remeasurement #1 to #2
JAN 1 – DEC 31, 2005	Remeasurement 3:	Not available					
	Remeasurement 5:						Chi-square test Significant decrease p=0.000 Baseline to Remeasurement #2

#3 Quantifiable Measure: Rate of Emergency Department (ED) Visits for members with Persistent Asthma							
Time Period Measurement Covers	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**	**Statistical Test and Significance***
JAN 1 – DEC 31, 2002	***Baseline:*** ***Continuous Enrollment***	165	250	66	69.9	69.9	Chi-square test Significant increase p=0.001 Baseline to Remeasurement #1
JAN 1 – DEC 31, 2003	***Remeasurement 1: Continuous Enrollment***	199	252	78.9	69.9	69.9	Chi-square test Significant decrease p=0.000 Remeasurement #1 to #2
JAN 1 – DEC 31, 2004	Remeasurement 2:	249	768	32.4	69.9	50.0	Chi-square test Significant decrease p=0.000 Baseline to Remeasurement #2
JAN 1 – DEC 31, 2005	Remeasurement 3:	Not available					
	Remeasurement 5:						

*** Please note: Based on VPHP's analysis, 2005 data is not comparable to previous year's data due to the continuous enrollment criteria. The Plan will not be able to report comparable data for 2005 until June 2006.**

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That the Analysis Covers.

Time Period 1: HEDIS DCY 2003 - MY 2002 (Baseline Year)

- One or more prescriptions for cromolyn sodium , aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma
- Rate of Hospital Admissions for members with Persistent asthma
- Rate of Emergency Department (ED) Visits for members with Persistent asthma

Time Period 2: HEDIS DCY 2004 - MY 2003

- One or more prescriptions for cromolyn sodium , aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma
- Rate of Hospital Admissions for members with Persistent asthma
- Rate of Emergency Department (ED) Visits for members with Persistent asthma

Time Period 3: HEDIS DCY 2005 - MY 2004

- One or more prescriptions for cromolyn sodium , aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma
- Rate of Hospital Admissions for members with Persistent asthma
- Rate of Emergency Department (ED) Visits for members with Persistent asthma

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

Quantitative Analysis: Quality Control in Asthma Management

QM#1: One or more prescriptions for cromolyn sodium , aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma

In MY2002 (baseline year), the Plan exceeded the comparison benchmark and comparison goal by 4.6 percentage points each. In MY2003, the Plan's rate was 0.1 percentage points lower than MY2002. In MY2003, the Plan was 0.8 percentage point shy of both the comparison benchmark and the comparison goal. There was no statistically significant difference between MY2002 and MY2003. In MY2004, the Plan's rate was 8.7 percentage points higher than MY2003. In MY2004, the Plan exceeded both the comparison benchmark and the comparison goal by 6.5 percentage points. There was a statistically significant increase in MY2004 compared to MY2002 and MY2003.

QM#2: Rate of Hospital Admissions for members with Persistent Asthma

In MY2002 (baseline year), the Plan exceeded the comparison benchmark goal by 9 percentage points and met the comparison goal. In MY2003, the Plan's rate was 0.6 percentage points lower than in MY2002. In MY2003, the Plan was 8.4 percentage points shy of the comparison benchmark and 0.2 percentage points higher than the comparison goal. There was no statistically significant difference between MY2002 and MY2003. In MY2004, the Plan's rate was 13.8 percentage points lower than MY2003. There was a statistically significant decrease in MY2004 compared to MY2002 and MY2003.

QM#3: Rate of Emergency Department (ED) Visits for members with Persistent Asthma

In MY2002 (baseline year), the Plan fell below the comparison benchmark and comparison goal by 3.9 percentage points. In MY2003, the Plan's rate was 12.9 percentage points higher than in MY2002. In MY2003, the Plan was 9 percentage points higher than both the comparison benchmark and the comparison goal. There was a statistically significant increase between MY2002 and MY2003. In MY2004, the Plan's rate was 46.5 percentage points lower than MY2003. There was a statistically significant decrease in MY2004 compared to MY2002 and MY2003.

Qualitative Analysis: Quality Control in Asthma Management

The outcomes of this study were presented to the various Quality Committees at VPHP. The Committee made recommendations on how to further improve quality outcomes for members, thereby improving rates and decreasing costs. The Senior Medical Director chairs the Quality Committees or equally qualified designee, and meetings are held quarterly. Recommendations were presented based on clinical practice experience and clinical knowledge related to the management of asthma.

QM#1: One or more prescriptions for cromolyn sodium , aerosol corticosteroid and leukotriene modifiers for members with Persistent asthma:

Barrier: Lack of knowledge on most appropriate medications to prescribe for the management of asthma.
Opportunity: Increase knowledge through expert advice and guidance from contracted PBM and through research presented at the Pharmacy and Therapeutics Committee meetings.
Intervention: Focused meetings with P&T Committee and evidence based research from PBM and other national guidelines (ex. FDA, etc); distribution of guidelines; re-engineered the Asthma Disease Management Program; Created a dedicated unit that focus on the management of chronic diseases, to include asthma.

Barrier: Lack of office supplies necessary for the effective treatment and management of asthma
Opportunity: If supplies are readily available when members are at doctor offices, then doctors can educate members on proper use -- real time
Intervention: Physician offices have the equipment (i.e., nebulizers, spacers, peak flow meters, etc.) necessary to manage asthmatics and members are more equipped at managing their own disease process

QM#2: Rate of Hospital Admissions for members with Persistent asthma & **QM#3:** Rate of Emergency Department (ED) Visits for members with Persistent asthma:

According to the 2003 SOHC report, published by NCQA, the rate trends and variability in performance for the Appropriate Medications for People with Asthma are similar for the Medicaid plans. Due to the lack of compliance of asthmatics in the Medicaid population, it proves to be a challenge for Medicaid Plans nationally, which has been VPHP's experience as well. If members were compliant for QM#1, QM#2 and QM#3, the Plan's hypothesis would be proven true.

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention-planning activities.

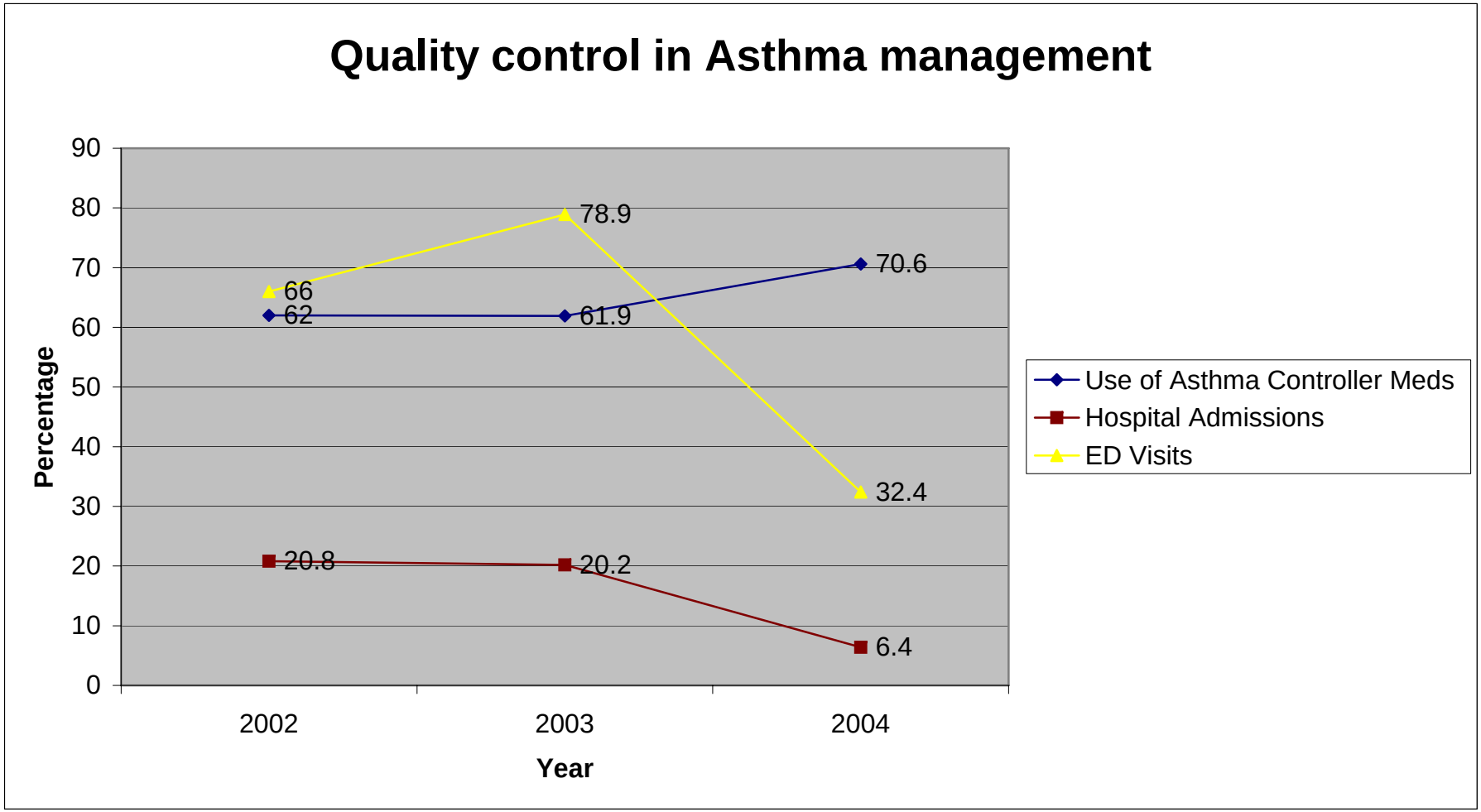
Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
May 2004	**X**	PCPs will receive a listing quarterly of members who are currently receiving prescriptions for asthma without long-acting beta-agonist inhalers as well as members who have been hospitalized or seen in the ED for an asthma diagnosis.	Providers not able to identify members to manage more effectively
June 2004	**X**	All newly identified members with a diagnosis of asthma will be sent a letter informing them of the Asthma management program and to contact VPHP's Health Educator for additional information.	Members lack of information regarding Asthma Management Program
August 2003	**X**	VPHP will identify PCPs with a high volume of asthma members and partner with the PCP to put peak flow meters and spacers in their office to dispense to members. In addition, these items are available through the member's pharmacy benefit and can be obtained with a prescription. Members with persistent asthma will be allowed a nebulizer to be kept at school if deemed medically necessary by their PCP.	Lack of readily available office supplies for asthma
February 2003	**X**	Members identified, as having persistent asthma will be contacted for individual case management with follow up with the member's PCP. VPHP's medical outreach staff will perform an in-home assessment on each member identified with persistent asthma including the member's self-assessment and quality of life survey	Lack of aggressive management from a Plan's perspective; lack of ability to ask questions on how to better manage disease process from a members perspective

February 2003	**X**	Members identified as having moderate asthma will receive education through enrollment in a community-based asthma education program. This program provides one-on-one or group instruction to help members and their families better understand the process related to asthma. Additionally, the program is designed to increase knowledge of prescribed medications, asthma triggers, and home maintenance of the asthma patient with 6 months f/u and evaluation.	Lack of understanding regarding Asthma program and medication management
February 2003	**X**	Members identified as having mild asthma will receive education through the mail from VPHP's Health Educator on self-monitoring, exercise, nutrition, weight management, medication and stress management.	Lack of proper tools to track and trend asthma outcomes
June 2004	**X**	Quarterly communications will be included in the Provider Newsletter of new formulary choices and asthma management strategies and resources. Educational information for members to enhance patient self-care asthma management will be included in the quarterly member newsletter.	Lack of continuous education related for members
June 2004	**X**	VPHP will partner with community-based agencies, hospitals, PHOs and providers to present an annual training for providers on the rationale for the guidelines, patient education techniques, the use of peak flow meters, and the proper use of inhaled steroids.	Lack of application of Plan guidelines related to asthma management
September 2004		Members with persistent asthma will be sent reminders to receive an annual flu shot.	Lack of members of getting flu shots
September 2004	**X**	The plan began by training its staff and practitioners about the rationale for the guidelines, patient education techniques, the use of peak flow meters, and the proper use of inhaled steroids. Interventions aimed at clinicians included monthly communication with primary care physicians (PCPs) about which of their patients had been enrolled in the educational program.	Lack of understanding and consistency in use of Plan guidelines

March – Present	**X**	Re-engineered Asthma Disease Program	Lack of comprehensive program to manage asthma
May 2005	**X**	Chronic Disease Program and Department Created and staffed	Lack of more aggressive approach to managing asthma
June 2005	X	Contracted with a biostatistician to provide statistical support for quality studies	Lack of expertise in house in statistical methodology and tools
June 2005	**X**	Quality of Life survey shall be implemented in conjunction with the re-engineered Asthma Disease Management Program and Chronic Disease Management Program.	Lack of correct member addresses; Lack of members completing the survey.

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.



QUALITY IMPROVEMENT ACTIVITY FORM

NCQA Quality Improvement Activity Form (an electronic version is available on NCQA's Web site)

Activity Name: Monitoring and Controlling the management with the use of two or more Atypical Antipsychotics

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

Rationale & Internal Data Analysis: In the United States, a recent concern has been the development of metabolic abnormalities including weight gain, dyslipidemia and hyperglycemia in patients on the class of medications known as the Atypical Antipsychotics. It has been well documented in the literature that patients who are receiving two or more Atypical Antipsychotics are more likely to develop diabetes and other metabolic abnormalities.[1,2,3]

Secondly, VPHP decided to study Atypical Antipsychotics because in MY 2004, 11.5% and 14.1% of the members were receiving treatment with two or more atypical antipsychotics from their Physicians and Psychiatrists respectively. Also 13.6% and 23.7% of the Physicians and Psychiatrists respectively prescribed treatment to the members with two or more atypical antipsychotics. We defined Psychiatrists and Non-Psychiatrists together as Physicians. About 200 or more VPHP members with Diabetes are prescribed with two or more Atypical Antipsychotics.

Problem Statement: There has been an increasing number of providers using two or more Atypical Antipsychotic medications for the same member and this could lead to development of diabetes and other metabolic abnormalities.

Opportunity for Improvement: With continued education, through the use of the TIMA guidelines and other interventions, the providers prescribing two or more Atypical Antipsychotics for members in Virginia Premier Health Plan, Inc. would be reduced.

B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician
Numerator:	Of the members in the denominator, those receiving two or more atypical antipsychotics in the measurement year
Denominator:	Total number of members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Physician in the measurement year
First measurement period dates:	January 1 – June 30, 2005
Baseline Benchmark:	NA
Source of benchmark:	NA
Baseline goal:	<10%

Quantifiable Measure #2:	Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Psychiatrist
Numerator:	Of the members in the denominator, those receiving two or more atypical antipsychotics in the measurement year
Denominator:	Total number of members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Psychiatrist in the measurement year
First measurement period dates:	January 1 – June 30, 2005
Benchmark:	NA
Source of benchmark:	NA
Baseline goal:	<10%
Quantifiable Measure #3:	Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Psychiatrist
Numerator:	Of the members in the denominator, those receiving two or more atypical antipsychotics in the measurement year
Denominator:	Total number of members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Non-Psychiatrist in the measurement year
First measurement period dates:	January 1 – June 30, 2005
Benchmark:	NA
Source of benchmark:	NA
Baseline goal:	<10%

Quantifiable Measure #4:	Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics.
Numerator:	Of the Physicians in the denominator, those prescribing two or more atypical antipsychotics in the measurement year
Denominator:	Total number of Physicians prescribing atypical antipsychotics in the measurement year
First measurement period dates:	January 1 – June 30, 2005
Baseline Benchmark:	NA
Source of benchmark:	NA
Baseline goal:	<10%
Quantifiable Measure #5:	Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
Numerator:	Of the Psychiatrists in the denominator, those prescribing two or more atypical antipsychotics in the measurement year
Denominator:	Total number of Psychiatrists prescribing atypical antipsychotics in the measurement year
First measurement period dates:	January 1 – June 30, 2005
Baseline Benchmark:	NA
Source of benchmark:	NA
Baseline goal:	<10%
Quantifiable Measure #6:	Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
Numerator:	Of the Non-Psychiatrists in the denominator, those prescribing two or more atypical antipsychotics in the measurement year
Denominator:	Total number of Non-Psychiatrists prescribing atypical antipsychotics in the measurement year

First measurement period dates:	January 1 – June 30, 2005
Baseline Benchmark:	NA
Source of benchmark:	NA
Baseline goal:	<10%
C. Baseline Methodology.	

QM#1: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician

Step 1: All members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Physician in the measurement year were abstracted

Step 2: Of those members identified as receiving atypical antipsychotics, those receiving two or more atypical antipsychotics were identified

Numerator: Of the members in the denominator, those receiving two or more atypical antipsychotics in the measurement year

Denominator: Total number of members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Physician in the measurement year

QM#2: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Psychiatrist

Step 1: All members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Psychiatrist in the measurement year were abstracted

Step 2: Of those members identified as receiving atypical antipsychotics, those receiving two or more atypical antipsychotics were identified

Numerator: Of the members in the denominator, those receiving two or more atypical antipsychotics in the measurement year

Denominator: Total number of members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Psychiatrist in the measurement year

QM#3: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Pyschiatrist

Step 1: All members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Non-Psychiatrist in the measurement year were abstracted

Step 2: Of those members identified as receiving atypical antipsychotics, those receiving two or more atypical antipsychotics were identified

Numerator: Of the members in the denominator, those receiving two or more atypical antipsychotics in the measurement year

Denominator: Total number of members 21 years and older enrolled in VPHP receiving atypical antipsychotics prescribed by a Non-Psychiatrist in the measurement year

QM#4: Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

Step 1: All Physicians prescribing atypical antipsychotics in the measurement year were abstracted

Step 2: Of those Physicians prescribing atypical antipsychotics, those prescribing two or more atypical antipsychotics were identified

Numerator: Of the Physicians in the denominator, those prescribing two or more atypical antipsychotics in the measurement year

Denominator: Total number of Physicians prescribing atypical antipsychotics in the measurement year

Effective July 1, 2004

QM#5: Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
Step 1: All Psychiatrists prescribing atypical antipsychotics in the measurement year were abstracted
Step 2: Of those Psychiatrists prescribing atypical antipsychotics, those prescribing two or more atypical antipsychotics were identified
Numerator: Of the Psychiatrists in the denominator, those prescribing two or more atypical antipsychotics in the measurement year
Denominator: Total number of Psychiatrists prescribing atypical antipsychotics in the measurement year

QM#6: Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
Step 1: All Non-Psychiatrists prescribing atypical antipsychotics in the measurement year were abstracted
Step 2: Of those Non-Psychiatrists prescribing atypical antipsychotics, those prescribing two or more atypical antipsychotics were identified
Numerator: Of the Non-Psychiatrists in the denominator, those prescribing two or more atypical antipsychotics in the measurement year
Denominator: Total number of Non-Psychiatrists prescribing atypical antipsychotics in the measurement year

The data is complete to our knowledge and we plan to audit the data to ensure validity and reliability of the data. The pharmacy data is collected by the data analysts at Perform Rx at Amerihealth Mercy. Data will be collected twice every year and will be analyzed every year. A chi-square test of statistical significance will be done comparing every remeasurement to the baseline and previous remeasurements.

C.1 Data Sources.

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[X] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):

_____
_____

_____
_____

C.2 **Data Collection Methodology**. Check all that apply and enter the measure number from Section B next to the appropriate methodology.	
If medical/treatment records, check below: [ ] Medical/treatment record abstraction If survey, check all that apply: [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Incentive provided [ ] Other (list and describe): _____ _ _____ _	If administrative, check all that apply: [ ] Programmed pull from claims/encounter files of all eligible members [ ] Programmed pull from claims/encounter files of a sample of members [ ] Complaint/appeal data by reason codes [X] Pharmacy data [ ] Delegated entity data [ ] Vendor file [ ] Automated response time file from call center [ ] Appointment/access data [ ] Other (list and describe): _____ _____ _____ _____

C.3 **Sampling.** If sampling was used, provide the following information. THIS SECTION IS NOT APPLICABLE

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.

[ ] Once a year
[X] Twice a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Once a week
[ ] Once a day
[ ] Continuous
[ ] Other (list and describe):

_____
_____

_____
_____

Data Analysis Cycle.

[X] Once a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Continuous
[ ] Other (list and describe):

_____
_____

_____
_____

C.5 Other Pertinent Methodological Features. Complete only if needed.

Data was collected from pharmacy records only.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size and sampling method
- Any introduction of bias that could affect the results

This section is not applicable, as there were no changes in the methodology.

Section II: Data / Results Table Complete for each quantifiable measure; add additional sections as needed.							
#1 Quantifiable Measure: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
July 1 – Dec 31, 2004	*Baseline:*	1054	9140	11.5	NA	<10	
Jan 1 – June 30, 2005	Remeasurement 1:	1294	10062	12.9	NA	<10	Chi-square test=7.876 Significant increase p = 0.005 Baseline to Remeasurement #1
July 1 – Dec 31, 2005	Remeasurement 2:	830	9951	8.3	NA	<10	Chi-square test=107.717 Significant decrease p = 0.000 Remeasurement #1 to #2 Chi-square test=54.534 Significant decrease p = 0.000 Baseline to Remeasurement #2
	Remeasurement 3:						
	Remeasurement 4:						

	Remeasurement 5:						
#2 Quantifiable Measure: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Psychiatrist							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
July 1 – Dec 31, 2004	*Baseline:*	684	4834	14.1	NA	<10	
Jan 1 – June 30, 2005	Remeasurement 1:	738	4991	14.8	NA	<10	Chi-square test=0.805 p = 0.370 Baseline to Remeasurement #1
July 1 – Dec 31, 2005	Remeasurement 2:	433	4621	9.4	NA	<10	Chi-square test=65.796 Significant decrease p = 0.000 Remeasurement #1 to #2 Chi-square test=51.803 Significant decrease p = 0.000 Baseline to Remeasurement #2
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#3 Quantifiable Measure: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Psychiatrist							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
July 1 – Dec 30, 2004	*Baseline:*	370	4306	8.6	NA	<10	
Jan 1 – June 30, 2005	Remeasurement 1:	556	5071	11	NA	<10	Chi-square test=14.717 Significant increase p = 0.000 Baseline to Remeasurement #1
July 1 – Dec 31, 2005	Remeasurement 2:	397	5330	7.4	NA	<10	Chi-square test=38.595 Significant decrease p = 0.000 Remeasurement #1 to #2 Chi-square test=4.257 Significant decrease p = 0.039 Baseline to Remeasurement #2
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#4 Quantifiable Measure:+	Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics						
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance
July 1 – Dec 30, 2004	*Baseline:*	390	2866	13.6	NA	<10	

Jan 1 – June 30, 2005	Remeasurement 1:	469	2997	15.6	NA	<10	Chi-square test=4.881 Significant increase p = 0.027 Baseline to Remeasurement #1
July 1 – Dec 31, 2005	Remeasurement 2:	555	3362	16.5	NA	<10	Chi-square test=0.866 p = 0.352 Remeasurement #1 to #2 Chi-square test=10.110 Significant increase p = 0.001 Baseline to Remeasurement #2
#5 Quantifiable Measure:+	Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics						
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance
July 1 – Dec 30, 2004	*Baseline:*	208	879	23.7	NA	<10	

Jan 1 – June 30, 2005	Remeasurement 1:	219	874	25.1	NA	<10	Chi-square test=0.462 p = 0.497 Baseline to remeasurement 1
July 1 – Dec 31, 2005	Remeasurement 2:	252	879	28.7	NA	<10	Chi-square test=2.909 p = 0.088 Remeasurement #1 to #2 Chi-square test=5.700 Significant increase p = 0.017 Baseline to Remeasurement #2
#6 Quantifiable Measure:+	Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics						
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance
July 1 – Dec 30, 2004	*Baseline:*	182	1987	9.2	NA	<10	

Jan 1 – June 30, 2005	Remeasurement 1:	250	2123	11.8	NA	<10	Chi-square test=7.469 Significant increase p = 0.006 Baseline to remeasurement 1
July 1 – Dec 31, 2005	Remeasurement 2:	303	2483	12.2	NA	<10	Chi-square test=0.198 p = 0.657 Remeasurement #1 to #2 Chi-square test=10.569 Significant increase p = 0.001 Baseline to Remeasurement #2

*If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

+ There may be some health care providers who are prescribing one atypical antipsychotic for one member and two or more atypical antipsychotics for another member.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

Time Period 1: MY 2004 (Baseline Year)

- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician
- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Psychiatrist
- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Psychiatrist
- Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
- Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
- Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

Time Period 2: Remeasurement #1 Year

- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician
- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Psychiatrist
- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Psychiatrist
- Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
- Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
- Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

Time Period 3: Remeasurement #2 Year

- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician
- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed

by a Psychiatrist
- Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Psychiatrist
- Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
- Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics
- Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

Quantitative Analysis:

QM#1: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Physician.

In MY2004 (baseline year), the Plan exceeded the comparison goal by 1.5 percentage points. In Remeasurement #1, the Plan's rate was 1.4 percentage points higher than baseline. The Plan exceeded the comparison goal by 2.9 percentage points. There was a statistically significant increase in Remeasurement #1 compared to baseline. In Remeasurement #2, the Plan's rate was 4.6 percentage points lower than Remeasurement #1. The Plan was 1.7 percentage points lower than the comparison goal. There was a statistically significant decrease in Remeasurement #2 compared to baseline and Remeasurement #1.

QM#2: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Psychiatrist.

In MY2004 (baseline year), the Plan exceeded the comparison goal by 4.1 percentage points. In Remeasurement #1, the Plan's rate was 0.7 percentage points higher than baseline. The Plan exceeded the comparison goal by 4.8 percentage points. There was no statistically significant difference between Remeasurement #1 and baseline. In Remeasurement #2, the Plan's rate was 5.4 percentage points lower than Remeasurement #1. The Plan was 0.6 percentage points lower than the comparison goal. There was a statistically significant decrease in Remeasurement #2 compared to baseline and Remeasurement #1.

QM#3: Of the members receiving treatment with atypical antipsychotics, the percentage of those receiving two or more atypical antipsychotics prescribed by a Non-Psychiatrist.

In MY2004 (baseline year), the Plan was1.4 percentage points lower than the comparison goal. In Remeasurement #1, the Plan's rate was 2.4 percentage points higher than baseline. The Plan exceeded the comparison goal by 1.0 percentage point. There was a statistically significant increase in Remeasurement #1 compared to baseline. In Remeasurement #2, the Plan's rate was 3.6 percentage points lower than Remeasurement #1. The Plan was 2.6 percentage points lower than the comparison goal. There was a statistically significant decrease in Remeasurement #2 compared to baseline and Remeasurement #1.

QM#4: Of the Physicians prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

In MY2004 (baseline year), the Plan exceeded the comparison goal by 3.6 percentage points. In Remeasurement #1, the Plan's rate was 2.0 percentage points higher than baseline. The Plan exceeded the comparison goal by 5.6 percentage points. There was a statistically significant increase in Remeasurement #1 compared to baseline. In Remeasurement #2, the Plan's rate was 0.9 percentage points higher than Remeasurement #1. The Plan exceeded the comparison goal by 6.5 percentage points. There was a statistically significant increase in Remeasurement #2 compared to baseline but not Remeasurement #1.

QM#5: Of the Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

In MY2004 (baseline year), the Plan exceeded the comparison goal by 13.7 percentage points. In Remeasurement #1, the Plan's rate was 1.4 percentage points higher than baseline. The Plan exceeded the comparison goal by 15.1 percentage points. There was no statistically significant difference between Remeasurement #1 and baseline. In Remeasurement #2, the Plan's rate was 3.6 percentage points higher than Remeasurement #1. The Plan exceeded the comparison goal by 18.7 percentage points. There was a statistically significant increase in Remeasurement #2 compared to baseline but not Remeasurement #1.

QM#6: Of the Non-Psychiatrists prescribing treatment with atypical antipsychotics, the percentage of those prescribing two or more atypical antipsychotics

In MY2004 (baseline year), the Plan was 0.8 percentage points lower than the comparison goal. In Remeasurement #1, the Plan's rate was 2.6 percentage points higher than baseline. The Plan exceeded the comparison goal by 1.8 percentage points. There was a statistically significant increase in Remeasurement #1 compared to baseline. In Remeasurement #2, the Plan's rate was 0.4 percentage points higher

than Remeasurement #1. The Plan exceeded the comparison goal by 2.2 percentage points. There was a statistically significant increase in Remeasurement #2 compared to baseline but not Remeasurement #1.

B.2 For the qualitative analysis, describe any analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following:

QMs # 1-6:

AFTER BASELINE MEASUREMENTS:

Barrier #1: Lack of Clinical Guidelines
Intervention: Developed, implemented and distributed clinical guidelines to healthcare providers

Barrier #2: Lack of Member Identification
Intervention: Notified providers of all members assigned to panel on two or more atypical antipsychotics

AFTER REMEASURENT #2:

Barrier #1: Use of generic letters to providers
Intervention: Personalize letters to providers emphasizing risks associated with using two or more atypical antipsychotics

Barrier #2: Lack of education with guidelines to new providers
Intervention: Send letters to all new providers in the network prescribing atypical antipsychotics since expansion

Barrier #3: Limited access to psychiatric services in various regions of the state
Intervention: Monitor geographical access to behavioral health services

Barrier #4: Exclusion criteria for members who require other forms of delivery
Intervention: Identify members receiving injectable long acting atypical antipsychotics and exclude from the analysis

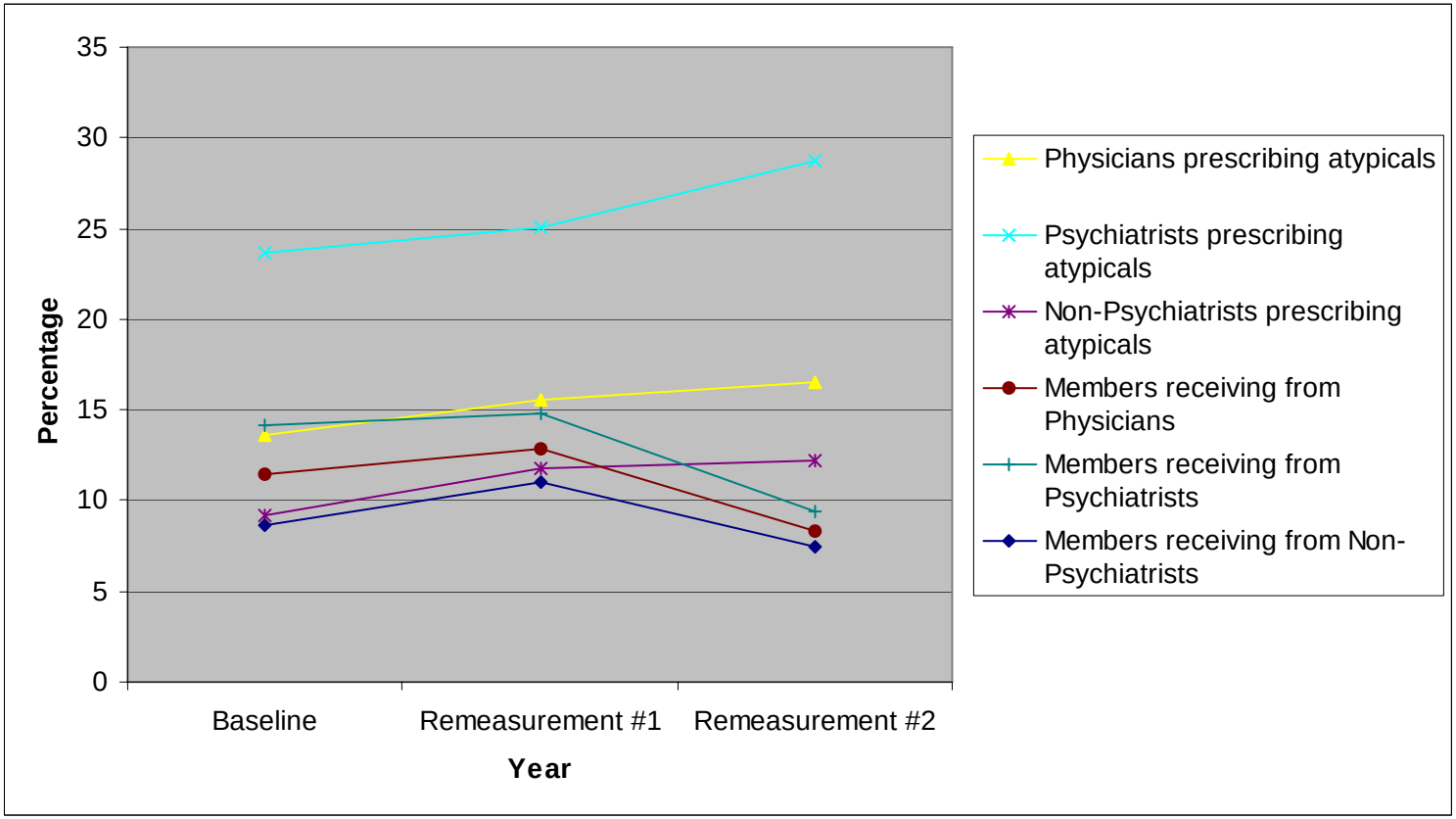
Section IV: Interventions Table

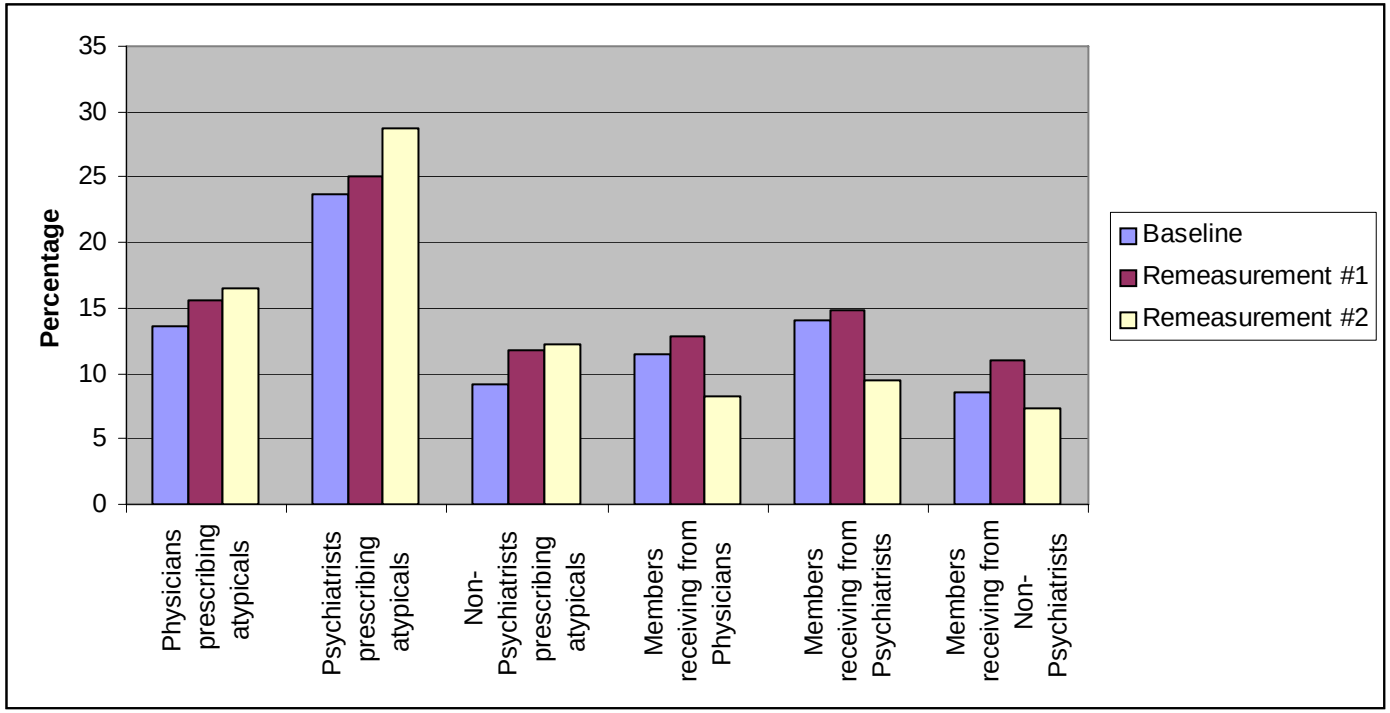
Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
10/04		Adoption of Clinical Guidelines	Lack of clinical guidelines
12/04	X	Distribution of guidelines to providers	Lack of clinical guidelines
12/04		Notification to providers w/listing of members on their panel w/2 or more atypical antipsychotic drugs	Identification of members
2/06	X	Personalize letters to providers emphasizing risks associated with using two or more atypical antipsychotics	Use of generic letters to providers
2/06	X	Send letters to all new providers in the network prescribing atypical antipsychotics since expansion	Lack of education with guidelines to new providers
2/06	X	Monitor geographical access to behavioral health services	Limited access to psychiatric services in various regions of the state
2/06	X	Identify members receiving injectable long acting atypical antipsychotics ad exclude from analysis	Exclusion criteria for members who require other forms of delivery

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.


35
30
25
20
15
10
5
0
Percentage
Baseline
Remeasurement #1
Remeasurement #2
Year
Physicians prescribing atypicals
Psychiatrists prescribing atypicals
Non-Psychiatrists prescribing atypicals
Members receiving from Physicians
Members receiving from Psychiatrists
Members receiving from Non-Psychiatrists



References:

1) Centorrino F, Goren JL, Hennen J, Salvatore P, Kelleher JP, Baldessarini RJ. Multiple versus sinle antipsychotic agents for hospitalized psychiatric patients: case-control study of risks versus benefits. American Journal of Psychiatry 2004; 161:700-6.

2) Taylor D, Young C, Esop R, Paton C, Walwyn R. Testing for diabetes in hospitalized patients' prescribed antipsychotic drugs. British Journal of Psychiatry 2004; 185:152-6.

3) Newcomer JW. Abnormalities of glucose metabolism associated with atypical antipsychotic drugs. Journal of clinical Psychiatry 2004; 65:Suppl 18:36-46